CULTURAL-LINGUISTIC CONSIDERATIONS WITHIN SPEECH-LANGUAGE PATHOLOGY IN EARLY CHILDHOOD

by

BHAIRVI M. TRIVEDI

(Under the Direction of Jennifer A. Brown)

ABSTRACT

The increasing diversification of the United States underscores the need for helping professionals, such as speech-language pathologists (SLPs), to continually self-evaluate their cultural competency. Culturally competent service delivery is imperative to maximize intervention outcomes for all populations, particularly those who are underserved. The majority of education on cultural competency for speech-language pathologists occurs during graduate school and continuing education opportunities. Therefore, the purpose of this two-study dissertation was to explore speech-language pathologists' and graduate SLP students' understanding of cultural competency and factors that impact their ability to serve culturally and linguistically underrepresented (CLU) populations. Both studies used semi-structured qualitative interviews and a phenomenological approach. Study 1 explored the perspectives of 10 SLPs working in early childhood settings to identify current practice patterns and potential barriers to service delivery that may be specific to early childhood. The SLPs reported minimal opportunities to learn about cultural competency in graduate school, with a majority of their knowledge being supplemented by continuing education sought independently or offered through their employer. Study 2 explored the perspectives of 12 graduate students who are currently

enrolled in a SLP master's program. The students reported various levels of exposure to education about cultural competency, with some being highly critical of the quality of their learning experiences. They also believed that cultural and linguistic differences may make it difficult to achieve clinician-client rapport, high quality of intervention, and best treatment outcomes. Nonetheless, participants in both studies felt it was ultimately the SLP's responsibility to navigate cultural-linguistic differences in order to ensure optimal service delivery for young clients and their families.

INDEX WORDS: Cultural-Linguistic Diversity; Early Childhood; Graduate Education; Speech-Language Pathology

CULTURAL-LINGUISTIC CONSIDERATIONS WITHIN COMMUNICATION SCIENCES AND DISORDERS IN EARLY CHILDHOOD

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DEDICATION

|| ॐ श्री गणेशाय नमः ||

Aum Shree Ganeshaya Namaha

I dedicate this dissertation to my family for guiding me through my education, and to my other half for pulling me through the finish line.

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CHAPTER 1

INTRODUCTION

In the past several decades, the population of the United States has expanded in the areas of race, ethnicity, language, religion, income level, and more (Pew Research Center, 2019; US Census Bureau, 2012). This contributes to increasing diversity in a variety of spaces or subgroups, particularly within healthcare and education. Therefore, the increasing cultural-linguistic diversity within the United States highlights the need for helping professions (e.g., clinicians, teachers) to continually self-evaluate their cultural competency. Consequently, the diversification within the United States parallels the increasing cultural-linguistic diversity among individuals with disabilities and in particular, communication disorders (Klingner et al., 2005). Speech-language pathologists (SLPs) are one type of professionals at the intersection of healthcare and education who are expected to consider and provide culturally competent services to individuals with communication disorders (American Speech-Language-Hearing Association [ASHA], 2004, 2008).

The American Speech-Language Hearing Association (ASHA), the professional organization for SLPs (henceforth used interchangeably with “clinicians”), states that cultural competency is the ability to appropriately understand, consider, and respond to the cultural variables of an individual (i.e., “culturally and linguistically diverse individuals”) and their family in order to optimize assessment and intervention services for them (ASHA, 2004). ASHA’s definition of cultural competency is inspired by Cross et al. (2014), who define culture as the “integrated patterns of human behavior” which comprise of the communication, actions,

language, customs, thoughts, institutions, and values of racial/ethnic, social, or religious groups. Cross et al. (2014) describe competency as the ability of an organization or individual to work and function effectively within the context of the cultural views, behaviors, and necessities presented by clients and their communities (Council on Academic Accreditation in Audiology and Speech-Language Pathology [CAA], 2017). Cultural competency is an ongoing process and involves recognizing what one does not know about the cultural-linguistic profiles of the individuals, families, and communities one serves. Cultural competency is a dynamic process, that occurs along a continuum and individuals may fall within a specific area of the continuum in different contexts (e.g., one may have greater cultural competency within a population they have worked closely with, but less cultural competency with others).

Cultural competency, per ASHA's definition, is increasingly important in speech-language pathology research and clinical practice. SLPs must work to minimize discriminatory practices and optimize "service with culturally and linguistically diverse (CLD) individuals." However, ASHA does not explicitly define what "cultural and linguistic diverse individuals" actually means. Since ASHA refers to CLD clients in consideration of cultural competency, one can infer that ASHA uses the term CLD to signify individuals who are historically underrepresented among ASHA professionals and the clients they serve (i.e., non-White and/or non-heritage English language speakers). The following studies are an examination of cultural competency within speech-language pathology as it relates to research and clinical practice with early childhood populations (i.e., ages 0 to 5 years) and beyond. This lays the foundation to inform a reexamination of culturally competent service delivery, particularly for young clients, and implications as the field moves forward.

ASHA Demographic Information

According to the US Census Bureau (2019), keeping demographic data on personal characteristics such as race is important because it provides information that is critical in making policy decisions, promoting equal employment opportunities, and examining disparities related to environmental and health risks. Workplaces and organizations tend to thrive with more diversity and implementation of culturally competent practice. At minimum, considerations of issues in cultural and linguistic diversity can contribute to growth in profits, sustainability of the organization and practices, and improved mentoring relationships (McCuiston et al., 2004; Ragins, 2007). ASHA's (2016b) most recent member and affiliate counts report that 92.2% of SLPs in the United States are White, followed by 3.5% Black/African-Americans, 2.5% Asians, 1.3% Multiracial, 0.3% American Indians and Alaskan Natives, and 0.2% Native Hawaiians and other Pacific Islanders. Although this information highlights that White people represent the vast majority of SLPs, the measures report does little to further describe the cultural-linguistic variation among their members. The only reference to ethnic variation among their members is presenting statistics on Hispanic or Latinos (3%) and not Hispanic or Latino (97%). In comparison, the US Census (2019) reports that 76.5% of individuals are White, followed by 13.4% Black/African-American, 5.9% Asian, 1.3% American Indians and Alaskan Natives, and 0.2% Native Hawaiians and other Pacific Islanders. 18.3% are Hispanic or Latino. Therefore, the diversity among SLPs in the US does not parallel the level of diversity in the US.

According to ASHA’s (2019b) bilingual service provider report, 11,259 of 191,904 SLPs in the US (i.e., 5.8%) identify as bilingual service providers, compared to 20.6% of individuals in the US who speak a language other than English (Ryan, 2013). However, similar to ASHA (2016b), this report only provides information on broad ethnic identities of bilingual service

providers (e.g., Hispanic/Latino or non-Hispanic/Latino). There is little information on the linguistic profiles of bilingual SLPs aside from Spanish-English bilingual service providers. Although this information may be considered beneficial for Spanish-speaking clinicians and clients, the data is not informative for clinicians and clients who speak a non-English language other than Spanish. This is particularly uninformative if they speak a language that has a low lexical similarity to English. For example, a South Asian language and English are significantly more distinct than the differences in Spanish and English (Ringbom & Jarvis, 2009). It may be difficult for SLPs to meet the expectation for providing culturally competent services to their clients if their professional organization (i.e., ASHA) under-investigates the cultural-linguistic diversity within their own field. Therefore, inadequate documentation of demographic information among members makes it difficult to understand the true level of diversity within the profession. It limits the diversity in perspectives ASHA can gain form their own members and apply it to research and clinical practice.

Terminology

Although there are some clinical guidelines and approaches that are universally applicable, it is difficult to establish normative terms in a diverse society. There is not an agreed upon set of terms that best describes the process, practice patterns, and descriptors used to characterize effectively understanding, valuing, and working with individuals from various cultures, developing positive attitudes towards cultural differences, and representing individual demographics. Recognizing the need for understanding the concepts behind terms as well as continually evaluating and revising terms is a key component to increasing effective interaction and service delivery across cultures.

Cultural competence. Although widely used, the term cultural competency has been challenged because "competency" may imply that cultures are finite, it infers that "cultural competency" is a skill that can be fully mastered, and it suggests a binary construct (e.g., either culturally competent or culturally incompetent), which may lead to stereotyping of individuals and inadequate individualization and delivery of services to underrepresented populations (Tervalon & Murray-Garcia, 1998), In contrast, in many health, educational, and clinical service delivery contexts, cultural competency has been described as the foundation for cultural humility. In this model, a clinician is on a continual process of becoming culturally component by developing cultural self-awareness, developing positive attitudes toward cultural differences, gaining cultural knowledge, and developing communication and interactional skills, which provides the foundation for practicing cultural humility. Cultural humility focuses on a commitment to ongoing self-evaluation, understanding and addressing power imbalances, and holding systems accountable. A culturally competent clinician practices cultural humility and chooses intervention practices that are culturally responsive and culturally sensitive (Greene-Moton & Minkler, 2020; Hall & Johnson, 2020; Paris & Alim, 2014, Stubbe, 2020). This is the model that will be used throughout this paper when referring to cultural competence (see Figure 1.

Cultural and linguistic diverse (CLD). Most "CLD" clients are seen by SLPs with whom they do not share a racial-ethnic or linguistic background (Guiberson & Atkins, 2012; Reeves & Beverly-Ducker, 2008). Accordingly, many SLPs are often faced with difficulties communicating with linguistically diverse clients and their families. Although the aforementioned studies refer to some aspect of CLD, they do not explicitly define it. Based on the populations they use in reference to CLD, it can be inferred that "CLD" populations refer to

any groups of people who are underrepresented, marginalized, or considered minorities relative to the United States' population. Alternatively, CLD can be considered a euphemism for individuals who are not White L1 English speakers because "culture" is often associated with people of color and/or people who speak languages other than English (Locke, 2005; Preis, 2013). In this context, "White" refers to individuals of European descent who historically hold societal privileges due to their skin color (DiAngelo, 2018; Macintosh, 1998). L1 English speakers refer to individuals who speak English as their first, native, and primary language. American L1 English speakers are commonly referred to as "monolingual." However, Matsuda & Duran (2013) argue that this is problematic because it normalizes English monolingualism and dismisses the diverse linguistic experiences of L1 English speakers. This may also imply White L1 English-speakers as the norm and CLD individuals outside of this group as unusual. This centers and empowers English and Whiteness, which may insinuate that other languages or races are inferior (Bhatt, 2010; Macintosh, 1998; Mufwene, 2010).

Semantically, CLD would be an appropriate term to use when describing the level of diversity within a group of people. For instance, one can say that a student population at a school is CLD because it is heterogenous. However, this is not how this term is always used within speech-language pathology; CLD is frequently used as a categorical descriptor (e.g., "The client is CLD"). Since diagnostic and clinical services should be individualized, it is inappropriate to use CLD as a way to identify or categorize individuals. Similarly, it would not make sense to label an individual as culturally and linguistically homogenous. The classification of CLD may promote a hierarchy by centering a dominant culture and language and may not meaningfully describe any particular group of individuals. Thus, the terms "culturally and linguistically diverse," "culturally diverse," and "linguistically diverse" as classifiers are minimally

descriptive. Because "CLD" is minimally descriptive as a classifier, for this dissertation culturally and linguistically underrepresented (CLU) will be used to refer to clients whose culture and/or linguistic background in underrepresented in the context they are being served.

Minority Language Speakers. Minority language speakers are individuals who speak a language that is underrepresented in the spaces that they live or occupy (e.g., geographical location, workplace, school). When working with minority language speakers, the current literature advises SLPs to find resources in another language or refer to an SLP who speaks the family's native language. However, this solution may be less effective when a family speaks a minority foreign language that does not have established support or resources as more common foreign languages (Kohnert et al., 2005).

The level and style of communication between clinicians and families also strongly impacts the diagnostic and treatment progress, and language differences or barriers add another dimension to this problem. For example, there are many SLPs who may be hesitant or less conservative when diagnosing a CLU individual (Dollaghan & Horner, 2011; Kritikos, 2003; Roseberry-McKibbin, 1994). As a result, there are clinicians who may be under-identifying or over-identifying communication disorders in minorities and developing inadequate treatment plans because they are unsure how much of the child's communication abilities are a reflection of their cultural or linguistic background.

Training Future Speech-Language Pathologists

Graduate SLP programs are required to include cultural-linguistic competency (i.e., as a part of clinical competency) in their curricula to prepare students to better serve culturally and linguistically diverse individuals (CAA, 2017). Master's students must graduate from a program accredited by the Council on Academic Accreditation in Audiology and Speech-Language

Pathology (CAA) in order to become an SLP and be eligible for the certificate of clinical competence (CCC; CAA, 2017). The CAA stipulates that master's programs provide graduate students with knowledge and skills across the nine Professional Practice Competencies, one of which is cultural competency. Within this requirement, students need to demonstrate "attributes and abilities" of cultural competency (CAA, 2017). Other competencies include evidence-based practice, concern for individuals served, and collaborative practice.

The requirements for cultural competency and the manner in which it is fostered at the graduate level are generally vague and at the discretion of the program. However, ASHA provides several resources online for students and clinicians to build cultural competency through the Multicultural Affairs and Resources Practice Portal, which offers "access to resources to guide evidence-based decision-making on clinical and professional issues" (ASHA, 2019c). Resources include self-assessments for cultural competence, clinical practice resources on working with underrepresented populations (e.g., transgender voice, phonemic inventories for various languages, internationally adopted children). Additional resources for instructors include Lubinski et al. 's (2008) guide to implementing cultural competence in their curriculum, including abbreviated sample syllabi on how "multicultural/multilingual (MMI) infused" courses may look in various subtopics within speech-language pathology (e.g., dysphagia, fluency and voice, bilingual/cross-cultural assessment, applied sociolinguistics)

Speech-language pathology graduate program directors report adequately preparing students for working with CLU populations (Hammond et al., 2009). However, actual implementation of these resources and techniques highly depends on initiatives and careful planning from university faculty. Furthermore, ASHA's tools provide surface level information on working with CLU populations and require additional preparation by the faculty

member/instructor (e.g., creating the actual lectures for MMI infused courses). Research also shows that SLPs, particularly White monolingual-English speakers, feel that their programs did not adequately prepare them for working with CLU populations, and they quickly experience "burn-out" which negatively impacts SLP attrition in certain communities (e.g., urban, predominately Black/African-American, bilingual) (Farrugia-Bernard, 2018; Guiberson & Atkins, 2012; Santhanam et al., 2019; Trembath et al., 2016)

Nonetheless, researchers support that the development of cultural competence highly depends on experiences in graduate school including coursework, clinical placements, and mentorship experiences (Cornish & White, 2016; Hammond et al., 2009; Howells et al., 2016). The ASHA Office of Multicultural Affairs. (n.d.) provides suggestions on curriculum-wide approaches for fostering cultural competence in graduate programs. These approaches include the pyramid approach, unit approach, course approach, and infusion approach first discussed in the ASHA Committee on the Status of Racial Minorities (1987) (See Figure 2).

The pyramid approach consists of a sequence of courses related to multicultural populations in which course build on one another. The unit approach involves adding a "multicultural content unit" in a course. The course approach includes having at least one course focused on bilingual or multicultural content. The infusion approach includes embedding bilingual/multicultural content throughout courses (ASHA Committee on the Status of Racial Minorities, 1987; Walters & Geller, 2002). Unit and course approaches are the most popularly used (Stewart & Gonzalez, 2002).

While integrating opportunities in curricula is important, Stewart & Gonzalez (2002) caution that faculty and administrators should do so in an organized and intentional manner. The goals of these curriculum approaches are to make sure that students are able to gain a foundation

in cultural competence and be able to apply it to other clinical contexts. It is imperative that the content covered in the curricula is not seen as "peripheral to the understanding of communication sciences and disorders" (Walters & Geller, 2002). Additional suggestions for "academic and clinical cohesiveness" include biannual faculty retreats and in-service training and clinical and instructional faculty recruitment.

ASHA has publicly supported the need for greater cultural-linguistic diversity within the profession (Brook, 2012; Rodriguez, 2016). There are several studies and initiatives that discuss the importance of cultural competency when working with CLU clients, but very few that consider the experiences of minorities in the profession. Walters & Geller (2002) state that increasing diversity among SLPs may help enhance quality of services for CLU populations, and how the framework used to support cultural competency for "minority" students will also be valuable for "majority" students. Efforts may involve using nontraditional recruitment procedures to establish a diverse student body (Walters & Geller, 2002). Larger scale opportunities may include encouraging CLU students to apply to participate in the national ASHA Minority Student Leadership Program (MSLP) (ASHA, 1999), or using resources provided by ASHA to adapt the program to the state or university level.

Historically, efforts from minority clinicians have been known for increasing cultural competence within speech-language pathology. For instance, the National Black Association of Speech Language and Hearing (NBASLH) was formed in 1978 to better support the needs of Black professionals (SLPs and audiologists), students, and individuals with communication disorders (National Black Association for Speech Language and Hearing [NBASLH], 2019). NBASLH's efforts have also garnered awareness of the needs of other individuals of color and multilingual speakers, particularly Spanish-English bilinguals (Reeves & Beverly-Ducker, 2008).

Ethnocentrism and Stereotypes

Students, clinicians, and researchers may also benefit from examining how certain privileges (e.g., racial, cultural, linguistic, or socioeconomic) can create biases in their own practices, and how greater awareness of these privileges can be used to build cultural competency (Farrugia-Bernard, 2018; Kohnert, 2013; Preis, 2013). This is because centering a particular group of individuals as the norm may lead to creating generalizations about certain groups that are not useful, and potentially harmful, in research and clinical practice. Texts commonly used by students may unintentionally present stereotypes about particular populations which may not be particularly meaningful and useful in practice. For instance, Roseberry-McKibbin & Pratt (2014)'s chapter on *Communication disorders in a multicultural world* provides descriptions that may lead to reinforcing stereotypes. While the chapter does point to the importance of being mindful of language differences vs. disorders, it also mentions broad stereotypes about cultural groups that may be detrimental if adhered to in clinical practice. Specific lists of "cultural tendencies" from various racial-ethnic groups (e.g., Asian, Hispanic, Black/African-American) is problematic because it ignores the complexity within each broad group. Also, the "cultural tendencies" that are listed may not be limited to that particular culture (e.g., "African-American children often respond well to a therapy approach that is warm and interactive…"). Furthermore, the text compares and contrasts "mainstream American beliefs and values" and "other culture's beliefs and values" in a way that is ethnocentric instead of being culturally relative, which happen to be terms that are accurately described within the chapter (Roseberry-McKibbin & Pratt, 2014).

Instructing students to memorize lists of cultural tendencies from particular cultural groups can enforce stereotypes and minimally contributes to their cultural competency (Chang et

al., 2012; Tervalon & Murray-Garcia, 1998). Instead, Hofstede (2011) recommends using cultural dimensions as a more individualized approach to understanding one's culture. For example, taking the time to learn how a particular client and their family differ in their views within certain cultural dimensions (e.g., child-rearing practices, health care, family dynamic, education) will be more informative for clinical practice than starting therapy with preconceived, and often inaccurate, generalizations.

Moving Forward

Inappropriate diagnosis, referral, and treatment of communication disorders is often linked to inadequate communication between clinicians and clients' caregivers (e.g., family members, parents). This may range from difficulties with communication due to language differences or a clinician's inability to gauge the family's cultural perceptions on disability, assessment, and intervention (Guiberson & Atkins, 2012). So far, there have been ongoing and formalized efforts to increase awareness of cultural competency for SLPs at various levels. However, there is a tendency in SLP research and clinical practice to overgeneralize the experiences of minority populations, which undermines the complexity and individualization required for all clients. This approach does not foster critical thinking in regard to providing culturally competent services and adapting assessment and treatment approaches to particular populations. Representation among speech-language pathology professionals, as well as gaining insight directly from community members, initiated ongoing efforts to address the needs of underrepresented professionals, students, and clients. Therefore, greater cultural-linguistic diversity within speech-language pathology, reevaluation of problematic research and clinical practices, and greater communication with clients and their family/caregivers may help support the needs of the greater community connected to speech-language pathology.

CHAPTER 2

STUDY 1: EARLY CHILHOOD SPEECH LANGUAGE PATHOLOGISTS' PERCEPTIONS ON CULTURAL COMPETENCY AND LINGUISTIC DIVERSITY

Speech-language pathologists (SLPs) have integral roles in the diagnostic and intervention process of communication disorders across the lifespan (American Speech-Language-Hearing Association, (ASHA) 2008a). SLPs are provided educational experiences to gain knowledge and skills in providing culturally competent services as a part of their clinical competency (CAA, 2018). According to ASHA, cultural competency is the ability to appropriately understand, consider, and respond to the cultural variables of an individual (i.e., "culturally and linguistically diverse") and their family in order to optimize assessment and intervention services for them (ASHA, 2004). ASHA states that cultural competency is increasingly important in SLP practice since the United States is diversifying and SLPs must work to minimize discriminatory practices and optimize services for culturally and linguistically underrepresented (CLU) clients in the United States. Cultural competence as a clinical model comprises developing positive relationships to cultural differences, gaining cultural knowledge, and building communication patterns which serves as the foundation for practicing cultural humility including ongoing self-evaluation and addressing power imbalances (ASHA, 2004). The following information is an exploration of the current literature within speech-language pathology on practices for assessment and intervention for CLU clients resulting in an overview of issues, recommendations, and gaps in the literature. This review informs the methodology for

a qualitative study exploring SLP perspectives in serving CLU clients in the context of early childhood settings (i.e., early intervention and preschool).

Recommended Practices for CLU Populations

For many SLPs, their first interaction with a CLU client is in the context of assessment. Across disciplines, assessments are necessary to characterize an individual's performance in a certain area (e.g., language, health, mobility) and inform appropriate decisions for intervention. Laing & Kamhi (2003) discuss that many standardized and norm-referenced (i.e., comparing an individual's performance to typically developing age-matched peers) language assessments used by SLPs are not appropriate for CLU populations because they are often overtly formal, decontextualized, and culturally/linguistically biased. So, they provide an overview of alternative assessment approaches to better characterize a CLU client's language abilities. Procedures for modifying the assessment process include collecting language samples for later non-standardized analysis. Within norm-referenced testing, the authors recommend using interpreters, providing additional verbal prompts, or rephrasing procedures. However, the recommendations described by Laing & Kamhi (2003) may not be applicable or appropriate for all CLU clients. For instance, the group representing the "culturally diverse" were African Americans and the group representing the "linguistically diverse" were native Spanish speakers. Furthermore, recommendations for culturally diverse compared to linguistically diverse clients were grouped into one category. Therefore, there was little differentiation between the groups regarding considerations, experiences, and/or recommendations.

Over generalization of findings are prevalent across the literature with CLU participants. There are several language studies with bilingual children that attempt to generalize their findings to all bilinguals, despite conducting research with only a particular group of speakers.

Gutierrez-Clellan (1999) discusses language choice in intervention with bilingual children by reviewing 12 intervention studies with various bilingual children (e.g., Spanish, Navajo, Vietnamese, French, and Hebrew). Although the author provides valuable suggestions for embracing a child's home language, the outcome measures for the studies reviewed represent varying aspects and levels of language (e.g., prepositions, word definitions, reading comprehension). Since each study included a particular group of bilingual children (e.g., only Spanish/English bilinguals) instead of a combination, the language outcomes for a specific group of children in a specific area of language (e.g., only measuring prepositions with Spanish/English bilinguals) should be interpreted and generalized with caution. Hammer et al. (2007) also made suggestions on language interventions for all bilingual Head Start students solely based on their experimental results with a group of Spanish-English bilinguals. As a result, some of the suggestions they provide for bilingual language intervention may not be feasible for all bilingual Head Start students. For instance, Head Start teachers of students speaking minority languages (e.g., Nepali) may not be able to apply the recommendations to have a clinician or teacher who speaks their native language instructing the child.

In bilingual language intervention research, overgeneralization could be harmful and misleading because it may ignore the environmental and cultural history of these languages in their specific context that may have made their results unique to that specific population (Kramsch & Widdowson, 1998). Research findings that are unique to a particular bilingual population can be insightful, but the authors need to be clear in how they present findings and limitations to demonstrate awareness and respect to cultural history and backgrounds of their participants. Most importantly, clinicians should be careful when interpreting the results of bilingual language research, and how they are able to apply these findings to their own clients.

Banerjee & Guiberson (2012) provide practical and appropriate guidelines for assessment of CLU populations in special education, while highlighting barriers preventing children from receiving appropriate evaluations. Instead of modifying norm-referenced assessments, they recommend using additional ecological (i.e., play or curriculum-based) approaches that assess the child's individual strengths and needs through adaptable/flexible assessment and determine what skills are functional in their natural home and school environments. Banerjee & Guiberson (2012) also discuss the importance of considering the child's family/caregivers as important collaborators during the assessment process and emphasize the importance of individualizing the assessment and intervention process for each child. Although these suggestions may be useful for serving CLU children, it is important to explore if and how SLPs are implementing these recommendations.

SLP Perspectives on Serving CLU Clients

SLPs are the bridge between research and practice, so they are responsible for implementing evidence-based practices for all clients. Consequently, examining SLP perspectives can provide valuable information for determining issues and developing feasible solutions in service delivery for CLU populations. Kritikos (2003) surveyed 100 SLPs across five states on their perceptions in assessing bilingual and bicultural individuals. The authors state that SLPs have different personal experiences with bilingualism. Some may be native bilinguals, some may have learned a foreign language in school, and others may have no personal experiences at all. However, most SLPs are unfamiliar with assessment and treatment of bilinguals and are more conservative when recommending treatment for CLU populations (Kritikos, 2003). As a result, many CLU individuals may be underserved by SLPs and true communication disorders are under identified or attributed to language differences. Guiberson &

Atkins's (2012) survey on SLP perspectives and practices when serving CLU populations highlights common issues that impact effective service delivery. These issues include language barriers and limited access to resources such as assessments in other languages or interpreters. The respondents were 97% white which aligns with the racial composition of SLPs across the country; however, the respondents were from Colorado, so they may not represent perspectives of SLPs. Therefore, exploring perspectives of a more geographically diverse sample of SLPs across the United States is necessary to obtain representative information. Although ASHA's membership lacks diversity relative to the US population, it does not mean members inherently lack cultural competence. Rather, intentional efforts are necessary to acquire and maintain culturally competency. Part of these efforts includes maintaining evidence-based practices and looking to research within speech-language pathology, which may provide insight on how to appropriately diagnose and treat a variety of clients.

Santhanam et al. (2019) surveyed 303 SLPs across the United States on their use of language interpreters as it is a common recommendation when working with linguistically diverse clients. The results demonstrated that having access to interpreters is merely the first step in the collaborative process as interpreters are most beneficial if the SLP has the competencies and knowledge on how to work with an interpreter. In-depth knowledge and skills on using interpreters may be addressed in differently across graduate programs. Santhanam et al. (2019) recommends that graduate programs encourage students to attend CLU service delivery workshops in interdisciplinary contexts (e.g., with a college of education or medical school). Practicing SLPs can attend in-person or web-based seminars on working with interpreters as a part of their continuing education.

Additional Perspectives

Quantitative surveys of SLP perspectives have provided insight into broad issues experienced by large numbers of SLPs in the field regarding cultural competency. Such issues include a lack of confidence in diagnosis and treatment, insufficient access to resources, and need for more education on CLU service delivery. SLP researchers frequently used quantitative methodologies in survey research because (a) the predominant close ended/multiple choice question format allows them to collect data faster, (b) quicker data collection can allow them to gain perspectives from larger number of respondents, and (c) quantitative data can be statistically analyzed (Damico & Simmons-Mackie, 2003). However, qualitative methodologies like interviews or focus groups can reveal new information that extends beyond quantifiable information.

Qualitative research has been conducted within issues in cultural and linguistic diversity across disciplines to better understand clients', caregivers, and clinicians' experiences with communication disorders. Compared to quantitative research, qualitative approaches can explore in-depth experiences of individuals or groups of people to enhance understanding of phenomena (Korstjens & Moser, 2017). Qualitative studies such as Hampton et al. (2017), Yu (2013), and Yu (2016) can explore the complexity of cultural and linguistically underrepresented populations and gain unique perspectives on issues (e.g., heritage language maintenance) that may not be obtained through quantitative methods (e.g., semi-structured interviews, focus groups). Such information can help researchers and clinicians develop a better understanding of diverse perspectives and help individualize assessment and treatment approaches for underrepresented clients.

Barriers in Early Childhood Settings

An overwhelming majority of linguistically underrepresented clients in the US are served by monolingual English-speaking SLPs (ASHA, 2008b; Guiberson & Atkins, 2012). Many SLPs are faced with difficulties communicating with linguistically diverse families, particularly in the context of early childhood special education settings: early intervention (EI) and preschool. In the United States, EI refers to Part C of the Individuals with Disabilities Education Act (2004) (IDEA), which is a federally mandated program of services for children with disabilities from birth to three years old. Part B, section 619 of IDEA is specifically designed for children ages 3 to 5 (i.e., preschoolers) with disabilities. Early childhood (0 to 5 years) is a developmentally critical age for establishing foundations in language and other skills for children of all abilities.

In the United States, recommended practice for SLPs in EI is to provide speech and language services in children's natural environments (including location, people, materials, and activities) by providing family-centered services (ASHA, n.d.). Family-centered EI services are individualized to address the family's priorities, reflective of the family's culture and values, and are focused on building family-capacity through a strengths-based approach (Woods et al., 2011). Intervention is provided in everyday routines and activities to increase child participation and to practice the skills in the situations in which they are functionally relevant (Brown & Woods, 2015; Dunst et al., 2007). EI providers support parents and caregivers through a routines-based coaching model. This model is centered on building caregivers' competence and confidence to support their child's development by coaching parents to embed intervention strategies within daily routines (e.g., meals, playtime, bedtime) (Brown & Woods, 2015; Hile et al., 2016; Friedman et al., 2012). Although there is increasing evidence for family-centered routines-based coaching in EI (Biel et al, 2020; Kemp & Turnbull, 2014), there remains a

divergence between what is recommended and what is being implemented by clinicians in the field (Campbell & Coletti, 2013; Hile, et al., 2016). Family-guided collaborative coaching is designed to build partnerships with families, educate and empower caregivers, and increase child participation in functional and meaningful activities through increased developmental skills. This approach to intervention, when implemented with fidelity, is inherently culturally sustaining. However, serving families with home languages that differ from the SLP's proficient languages remains a challenge in practical implementation.

According to IDEA Part B (2004) children 3-21 are entitled to a free and appropriate education (FAPE) in the least restrictive environment (LRE). Specifically, section 619 covers preschool special education services. SLPs may use a combination of service delivery methods in preschool settings including pull-out/direct service, push-in service, coteaching/parallel instruction, and intervention consultation (ASHA, n.d.; Justice & Redle, 2014). Pull-out/direct service involves taking a child outside of the classroom into another setting in the school (e.g., hallway or office) to provide intervention. Push-in services are classroom-based services where intervention is integrated within a classroom or school routine. In co-teaching/parallel instruction the SLP provides services with another clinician or educator. In intervention consultation, the SLP serves as a consultant, and oversees other professionals, caregivers, or family members implementing intervention strategies and/or collecting data. School-based services can potentially resemble some aspects of an EI intervention approaches. For example, providing intervention during a child's routine, collaborating with other professionals, or serving as a consultant. However, compared to EI, in preschool-based services there are fewer opportunities for direct communication with families (Pang 2010; Podvey 2013). As a result, SLPs may encounter more barriers in providing culturally sustaining services. There are fewer incidental

opportunities, and more effort required, for relationship building and providing knowledge and support (Starr et al., 2016). So, these limitations of preschools service delivery may be amplified when working with a child who shares a home language different from their SLP.

Problem Statement

When working with clients whose home language is not English, the current literature advises SLPs to find resources in another language or refer to an SLP who speaks the client's native language. However, this solution may be less effective when a client communicates in a minority, or underrepresented, foreign language (e.g., Nepali) that does not have established support or resources like more common foreign languages (e.g., Spanish; Kohnert et al., 2005). The level and style of communication between clinicians and families also strongly impacts the diagnostic and treatment progress, and language differences or barriers add another dimension to this problem. For example, SLPs may be hesitant or less conservative when diagnosing a child whose home or heritage language is not English (Roseberry-McKibbin, 1994; Kritikos, 2003; Dollaghan & Horner, 2011). Therefore, exploring SLP perspectives on cultural competency and serving linguistically underrepresented clients can provide more insight into how to improve communication and relationships to clients and their families. Doing so can contribute to ASHA's ongoing goal of increasing cultural competency of clinicians in order to optimize services for clients of all backgrounds and maximizing treatment outcomes (ASHA, 2004).

Purpose and Research Questions

There is a need for additional research on service delivery for clients who are culturally and linguistically underrepresented and a re-examination of SLP perceptions on cultural competency within this context. Service delivery for minorities within early childhood populations comes with its unique set of challenges and opportunities. Therefore, to identify

current practice patterns and potential barriers to service delivery that may be specific to early childhood, it is important to gain the perspectives of SLPs who are practicing in early childhood settings. The purpose of this study is to use a phenomenological approach to examine early childhood SLPs' perceptions on cultural competency, as well as factors that impact their ability to serve underrepresented clients and families, by exploring the following questions through a qualitative survey.

1. How do early childhood SLPs define cultural competency and linguistic diversity, and what is their self-perceived level of cultural competence?
2. What do SLPs report on the quality of pre-professional and professional courses, resources, or opportunities that foster cultural competency?
3. How does a client and their family's primary language impact the professional relationship with the SLP as well as the clients' intervention outcomes?

The information from this study can help clinicians and researchers reevaluate evidence-based approaches and terminology used when working with clients and families whose primary language is not English. Furthermore, the results may inform the best ways to support SLPs in the areas of continuing education and ongoing research to enhance the equitability of services for clients from various cultural-linguistic backgrounds.

Method

A phenomenological approach influenced the methodology of this study. Phenomenology is rooted in the concept that individuals who have experienced a phenomenon and are able to produce comprehensive descriptions of said phenomenon, are most appropriate for describing the fundamental structure of the phenomenon (Van Manen, 2016). This structure can be revealed when a phenomenon is examined over time and across various situations or perspectives. A

phenomenological approach is appropriate for this study because the aim is to explore commonalities among individual experiences (i.e., early childhood SLPs) to describe a particular phenomenon (i.e., service delivery for CLU populations) (Creswell, 2013). This may allow for a more universal explanation and genuine grasp of the phenomenon that is SLP perspectives on cultural competency and service delivery for CLU populations.

Reflexivity Statement

This research explores US-based speech-language pathologists' perspectives on cultural competency in serving CLU populations within early childhood in order to inform best research and clinical practices. The author of this study is Hindu, Indian-American, female, and her interest in this topic stems from her experiences as a multilingual speech-language pathologist and researcher with clinical and research experience with early childhood populations. The author also has experience and is invested in participating in community, university, and national-level initiatives to promote cultural competency among speech-language pathologists and other professionals in order to optimize service delivery for CLU populations. Like the participants, the author has experience working as an early childhood SLP and is generally aware of considerations for cultural competency, especially when working with underrepresented populations. As a CLU individual, the author also has personal experience from childhood working with and receiving services from SLPs and other helping professionals who do not share their cultural-linguistic background. However, the author does not work full-time as an early childhood SLP, and the majority of the work they have done is in the context of research or a university-affiliated setting. So, the author lacks full understanding of what it is like to work as a full-time early childhood SLP in a primarily clinical, and non-research, context. Therefore, interviewing full-time early childhood SLPs provided the author with insight that could not be

acquired from their own experiences or the current literature. Overall, the author's positionality impacted the direction of data collection and analysis, and also contributed to how the data was interpreted.

Participants and Setting

Approval from the Institutional Review Board was obtained before the study was implemented and participants were recruited. Participants for this study include SLPs who provide clinical services to early childhood populations. The aim of this study was to explore issues in cultural competency and linguistic diversity specific to the United States and the interviews were conducted in English. So, participants were SLPs proficient in English working in the United States. Participants were recruited online through information distributed via social media, university alumni listservs, and EI agency listservs. Sampling approaches were mixed, with purposeful sampling combined with convenience sampling. Purposeful sampling consisted of posting study flyers to online social media groups and listservs specific to early intervention SLPs. Convenience sampling consisted of reaching out to mutual acquaintances or colleagues to request them to share the recruitment information with their professional networks. Similarly, snowball sampling was used to recruit more participants by asking participants to share information about the study to their colleagues. Participants were selected for an interview based on a volunteer basis and availability. Geographical location was also considered in an effort to gain diverse SLP perspectives (e.g., interviewees from different states and regions as opposed to one city).

Ten participants were recruited because a smaller sample helped the researcher establish and maintain a closer relationship with participants and fostered more candid dialogue when exchanging information, aiming to improve the validity of in-depth inquiry (Crouch &

Mackenzie, 2006). The researcher also had a shared identity with the participants as an SLP with an interest in serving early childhood populations, which helped create a closer relationship with the participants and allow for more open discussion. Furthermore, the researcher positioned the SLPs as experts in their lived experiences and the researcher as someone learning from them. Data saturation was an additional criterion used to determine that this study had a sufficient number of participants (Fusch & Ness, 2015). When the responses were similar and repeated across participants, participation recruitment was concluded.

Of the ten participants, most were in the 25-34 age range and worked full-time as SLPs. Participants came from various states including Arkansas (n=1), Colorado (n=1), District of Columbia and Maryland (n=1), Georgia (n=1), Illinois (n=1), Texas (n=3), and Virginia (n=1). One participant was currently in Quebec, Canada, but received her graduate degree from the United States and has maintained her certificate of clinical competence. Seven participants were White, two were Hispanic, and one was South Asian. Four participants only communicated in English, whereas six knew Spanish (beginner to native proficiency), one knew French, one knew Italian, and one knew American Sign Language. All participants had master's degrees in speech-language pathology and one participant was pursuing a clinical doctorate. The participants provided early childhood intervention in settings including home, daycares, and preschools. See Table 1 for demographic information on participants. Participants needed access to a digital device (e.g., computer, tablet, smartphone) and internet connection as interviews took place online via Zoom, video conferencing software that allows shared simultaneous video and screen sharing (Zoom Video Communications Inc., 2016).Having sessions on Zoom replicated aspects of live face-to-face interactions (aside from body language or nonverbal communications) in the form of video, audio, and written text (i.e., instant messaging) (Archibald et al., 2019).

Furthermore, videoconferencing expanded the ability to communicate with individuals in different geographic locations on different devices (i.e., laptop, tablet, or phone). Zoom was particularly useful as a research tool because it encrypted the meetings in real-time, offered user-specific authentication (e.g., meeting passwords), and secure recording of sessions to later be used for transcription and analysis. The feasibility of obtaining consent digitally and conducting interviews via Zoom was tested with 1-2 individuals before interviews with final participants began.

Procedures

Before the interviews, demographic information was collected and tabulated via a Qualtrics survey (see Appendix A). All interviews were conducted with the same interviewer in English. The semi-structured interviews were approximately 30-45 minutes long and were audio recorded for later transcription and analysis. Interviews took place on Zoom video conferencing software at a time that was most convenient for participants. A predetermined list of open-ended questions was used to guide the interviews (see Appendix B). These questions asked participants about their perceptions of cultural competency and experiences learning and providing services for clients who are culturally and linguistically underrepresented.

Data Analysis

Thematic analysis was used to identify, analyze, organize, and describe the themes found in the data (Braun & Clark, 2006). The data analysis process involved three phases as described in Nowell et al., (2017): (a) familiarizing ourselves with the data; (b) generating initial codes; and (c) searching for themes (see Figure 3). In Phase 1, audio recordings of the interviews were transcribed on computer software NVivo (Bazeley & Jackson, 2013). Following transcription, the entire data set was read at least once before coding in order to identify possible patterns and

take notes for coding ideas. After becoming familiar with the data in Phase 1, the data were revisited in Phase 2 in order to generate initial codes. Through this process, the data were simplified and specific characteristics were indexed and labeled in specific and broader categories as they related to themes. Some codes included defining cultural competency, linguistic background, continuing education, telepractice, communication barriers. Coding approaches were documented throughout the data analysis process. Phase 3 began once all of the data were initially coded and a list of codes was developed. In Phase 3, all relevant coded data were reviewed before sorting and combining into themes that connected and describe significant components of the data. See Table 3 for codes and themes. In this way, the process of deriving themes from participants' responses was inductive because I examined patterns within the data to develop possible explanations for these observations (Braun & Clarke, 2006). These themes were examined to determine if and how they addressed the research questions as well as any additional conclusions that came from the data themes.

Validity

Approaches to ensure the validity of the findings included peer review of plans and methods as well as conducting member checks. The proposed plan and methodology of this study were peer-reviewed by four established researchers several times before data collection began. During the interview, member checks were also conducted. This included presenting data that were collected to the participants to confirm that the data accurately represented the participants' perspectives (Merriam, 1995). For example, throughout the interview the researcher repeated key points of the participants' responses to provide an opportunity to clarify or correct any statements. Audio recordings of the interviews were transcribed and reviewed by a research assistant, and then reviewed again by me. Afterwards, each transcript was reviewed twice for

accuracy. Then, themes and findings (i.e., written results, analysis, and discussions) were reviewed and assessed by multiple peer researchers at various stages in order to enhance the trustworthiness and credibility of the findings (Janesick, 2007).

Findings

Five major themes were constructed from the data: consistency in terminology, personal background and cultural competency, seeking learning opportunities, diving into telepractice, and clinician-client communication. These themes exemplify the lived experiences of the early childhood SLP participants related to their perspectives of their competency in working with CLU clients in their career.

Theme 1: Consistency in Terminology

All participants provided definitions of cultural competency that were consistent with statements from ASHA and with each other. They described cultural competency as something that encompasses awareness, humility, and sensitivity. Participants also noted the importance of recognizing their clients' values and not making assumptions about their beliefs and customs:

> *I would define it as an understanding, a sensitivity, and awareness to different cultures… Understanding and being sensitive and knowledgeable about their values (Participant 1)*

Most (more than half of) participants were not familiar with the term "linguistic diversity," but their attempts to describe it had some commonalities. They associated the term with recognizing the existence of different languages and linguistic systems as well as the effect it may have on an individual's linguistic repertoire:

> *Linguistic diversity is really a fun and interesting part of cultures. I think every, um, country probably has their own set of dialects that represent the group of people who lived there…but then also the influence that other languages have if the child has, you*

know, another language spoken in their home, the impact that would have on their English language and sort of considering that in my practice as an SLP. (Participant 8)

Although the participants had different levels of familiarity with term linguistic diversity, they all associated the term with tenants of cultural competency and, viewed clinical considerations for linguistic diversity similar to approaches to cultural diversity.

Theme 2: Personal Background and Cultural Competency

Many participants associated their level of cultural competency with their personal cultural-linguistic background and experiences with underrepresented populations. For instance, SLPs who did not identify as White, spoke a language other than English, has lived in a diverse location, or travelled internationally considered themselves to have a relatively high level of cultural competency:

Cultural competency was easy for me to grasp because of where I was born and raised. My parents are immigrants and I was raised in Miami, Florida… I had a very vast awareness of different cultures and languages and I was easily accepting of these differences, so it made the transition and the application of cultural competency into my field as a speech therapist a little bit easier… based on my background, my personal background or my experience, I would probably rate to be a little bit higher than most of my colleagues. (Participant 2)

Those who attended school in less diverse universities or communities felt less confident about their training in graduate school. On the other hand, those who attended school in more diverse areas felt like they had a stronger foundation in cultural competency:

I did graduate school in UT Dallas, so it's a very big metroplex to choose from for our opportunities…so that definitely brought a lot of cultures, but, everybody pretty much had access to those resources in my graduate program. (Participant 3)

Although the participants had varying self-reported levels of cultural competency, they all believed that cultural competency was an ongoing process, and that there was always more room for them to build upon it.

Theme 3: Seeking Learning Opportunities

Participants felt that their exposure to cultural competency in graduate school was minimal. Most (at least half of participants) had the option of taking an elective related to cultural competency (e.g., bilingualism) or had a lecture on it in one of their classes.

In grad school... man, I feel like... I mean, did we have a lecture... is what I would probably guess. I don't even... [sighs]... it was limited. We'll just say that. I feel like people probably touched on it as, like, a talking point, you know, one time in this class and maybe there was one lecture in another class, but I don't feel like... there was much, like, direct instruction or teaching on it. (Participant 5)

Overall, the participants felt underprepared for working with CLU populations upon finishing graduate school. Most of what they learned about cultural competency was as a practicing clinician through hands-on experience and continuing education:

You know, it's one of those things that there's always a dedicated slide for it on the Powerpoint in each class you go into, but you don't really think about it as much until as an SLP you get into a situation with a family who might be of a different culture than you. (Participant 3)

All participants felt that they were able to expand their cultural competency, particularly for bilingual populations, once they began working as an SLP. Trainings provided by their workplace and funding for continuing education helped somewhat, but many had to seek specific information on cultural competency on their own:

> *We were given money to attend CEU's, and we could bill for CEU's, and they would cover the CEU's, but they didn't give us specific trainings on being a culturally competent provider or SLP. So again, we had to look for that stuff on our own, um, the schools that I've-, I've worked at many, many schools, or at least contracted for many, many schools, and I haven't had any type of cultural competency training there. (Participant 7)*

They also critiqued pre-professional and professional training opportunities they had. At the graduate level, some wished their professors discussed cultural competency more in their classes by providing additional content knowledge and examples of real-life applications with CLU populations. With their workplaces, some felt their training opportunities were infrequent, provided insufficient information, or were not monitored enough since employees had to independently seek CEUs. Three also felt that although trainings were well-meaning, approaches to cultural competency were sometimes too aggressive:

> *I would say that the approach itself in the idea like in the initiative and in the initial thought process was really good…but at the same time, it almost seemed like if, and this might sound bad, but they're forcing it, forcing it, and if you don't do this you're racist…So it was not that people didn't want to do it, but it was like very, very pushed. And if you weren't doing this, you're not considered to be culturally competent and therefore you're being racist (Participant 11)*

Five participants noted the importance of reading research to remained informed on cultural competency. However, they found it difficult to relate to because reading journal articles are "not as fun" and they feel as if they were done in controlled setting. Three participants said they were able to relate and learn more easily to social media posts because the information was more applicable:

I also like to read real-world experiences [on social media], where it's not all done in a very vanilla lab or clinical setting where everything was very controlled. I like to just read real people's responses and the way they felt in a situation and then have other people come in who are from other cultures and say, well, this is how I would feel in that situation… And then a few other people chime in…people who know more about linguistics of another culture than I know like hearing their input…so I feel like there's just a lot of different real world, um, applications for reading in the Facebook groups. (Participant 8)

Theme 4: Diving into Telepractice

Since these interviews were conducted during the COVID-19 pandemic, participants also shared their experiences with teletherapy. None of the participants had any experiences with teletherapy. The transition was immediate for them, and they had to learn along the way, and independently educated themselves on it:

Well, first it was terrifying obviously, because it wasn't anything I was used to and teletherapy was always an option for SLPs like, the most of us were just like why? You can't high-five the kid or give them a hug or whatever. So it was scary. And my way of going was to just jump in, just-, just jump in as soon as possible and like rip off the band-

aid. So I spoke to a bunch of people who had done it… There were a bunch of Facebook groups that opened up about telepractice and so much free PDs. (Participant 9)

Although many participants received minimal support or training form their employers, they were sympathetic because it was a new and unprecedented situation. Many were also pleasantly surprised by how effective teletherapy was for their young clients. They were able to implement more evidence-based practices such as parent coaching, using toys in the child's natural, environment, and having opportunities to communicate more with parents and caregivers. This was especially important for families with cultural and linguistic differences from the SLP:

I actually have, um, better family involvement from some of my families because I didn't feel like I had the time to, like, reach out as much as I probably should have been before the pandemic… I switched to more of a consultation model, which, um, meant that I spent a lot more time talking to parents, having zoom meetings with parents, like to coach them through different things or emails. And some of my kids actually really improved that way. (Participant 6)

Overall, specific training on cultural competency and working with bi/multilingual populations was minimal in graduate school but was supplemented by professional continuing education opportunities and hands-on clinical experiences. Experiences providing teletherapy during the COVID-19 pandemic also enhanced their cultural competency. Nonetheless, all participants hoped for more support and educational opportunities from their graduate program and employers.

Theme 5: Clinician-Client Communication

All participants believed that a family's primary home language can impact how effectively they can communicate with one another. With English speaking clients, they felt they

were able to better relay information. With clients who did not speak English as a primary language, participants had to be more mindful in how they communicated with them, especially since some aspects of communication may be lost in translation:

> *I don't know if my message is coming off as loving and helpful as they make it seem, like, I don't know what word choices that translator is using. So, I think in terms of, like, providing a detailed analysis of the session, I think a language barrier would possibly put a damper on that. (Participant 7).*

However, bilingual participants felt more comfortable navigating these barriers. Also, all participants also thought that as an SLP, they are expected to face communication barriers and it's their responsibility to adapt as necessary. Regardless of a client's cultural-linguistic background, a meaningful effort to build rapport should be made.:

> *I always want to be very approachable and nice…I'm still going to be myself. I'm going to be the, you know, bubbly, loving, wonderful clinician that I am to that family. That's not going to change. (Participant 11)*

Many participants believed that the initial rapport with clients is sometimes difficult, and they initially are more efficient when working with families if they share a cultural-linguistic background. Although, others said that ultimately the intervention quality for young clients should not be significantly impacted by language differences. They also believed that although the rates of progress my look different, the overall progress they may should do be significantly different that clients who primarily speak English, especially since each case is so unique:

> *I think when done well it doesn't necessarily have to negatively impact my service delivery or their progress... my comfort level shouldn't be the determining factor for my outcomes, you know, but to some degree, you know, the more aware I am of a family's*

cultural situation or language, I can kind of get to work a little bit faster sometimes, like, it takes a little bit less time. I guess it could probably slow outcomes when there's more culture or language differences. (Participant 5)

Although language differences may initially impact service delivery and rapport with clients, most participants feel optimistic about the quality of intervention their client receives and their treatment outcomes. According to the participants, a clinician's skillset and strengths have the largest impact on a client's progress, regardless of their cultural-linguistic background.

Discussion

Cultural Competency and Confidence

Overall, the findings revealed that SLPs working with early childhood populations have a consistent and representative viewpoint of cultural competency: it is an ongoing process that involves awareness, humility, sensitivity, and continuous reflection. This aligns with the definition that ASHA provides about cultural competency (ASHA, 2004). This study was the first time most participants were exposed to the term "linguistic diversity." They were less confident defining it compared to cultural competency, but they acknowledged that there is variation in linguistic backgrounds, and one needs to be aware of it when providing services to clients.

When it comes to one's perceived level of cultural competency, findings revealed that SLPs who are a cultural-linguistic minority or have personal experiences with different cultures and languages (i.e., outside their work as an SLP) were more likely to consider themselves to have a higher level of cultural competency compared to those who were White, monolingual SLPs with minimal personal experiences with cultures different from their own. Although diversity in the profession and applying valuable personal experiences is important for enhancing

overall cultural competency in the field, SLPs who have potential to have a high level of cultural competency should not be discouraged and immediately be seen as less fit due to their personal background and experiences. Per ASHA (2004), there is potential for any SLP to be an effective clinician for any client if they continuously educate themselves and appropriately implement culturally competent services.

Learning Experiences

Although the early childhood SLP participants show a strong awareness of what cultural competency entails, their graduate experiences learning about it as a whole were minimal. They were expected to learn about cultural competency, and working with bi/multilingual populations, independently or in their post graduate professional career. It has been previously established that cultural competency is an ongoing process, and there is no finite end goal of achieving full cultural competency (ASHA, 2004; Lubinski et al., 2008; Lynch & Hanson, 1992). So, self-guided learning should be expected to some degree. However, if many early childhood SLPs have to learn about cultural competency and working with CLU populations independently with minimal guidance, they may not have received an adequate foundation in it during their graduate studies. This is also concerning because cultural competency may be viewed as optional auxiliary clinical skills instead of something that should be weaved throughout their clinical practice.

Some SLPs had opportunities to learn about cultural competency through trainings offered via their workplace, but they expressed concerns that the approach was sometimes too aggressive. SLPs were made to feel inherently inadequate or racist, which can discourage them from feeling like they have the potential to become more culturally competent and feel comfortable working with CLU populations. They may also view the community of

professionals who are passionate about cultural competency as unapproachable, patronizing, or elitist. This may make them less willing to be responsive to educational opportunities about it. This is a challenging balance because prior research has discussed that feelings of discomfort or inadequacy is typical when clinicians first participate in sensitive discussions about multicultural issues and racism (DiAngelo, 2018; Kohnert 2013; Preis, 2013). Nonetheless, “aggressive” approaches to teaching cultural competency, especially in speech-language pathology, is worth examining in future research.

SLPs may also have difficulty learning about cultural competency through information that is disseminated through research articles. Many find it difficult to approach because they are unable to access research, are not accustomed to reading research, have little time to absorb the information, or have difficulty applying it to their own clinical practice. These experiences are consistent with previous studies exploring SLPs’ access to research and implementation of evidenced-based practices (Thome et al., 2020, Zipoli & Kennedy, 2005). However, the participants reported learning more from colleagues and social media posts that share experiences more reflective of the situations they encounter in their own clinical practice. So, further exploration on how different sources, especially social media, can be used to educate clinicians on cultural competency may work towards improving the gap between research and clinical practice.

Experiences with Service Delivery

The COVID-19 pandemic dramatically impacted services delivery for all SLPs, especially those working with early childhood populations. While SLPs may be critical of the general training and supports that are provided by their workplaces, they were generally understanding of the difficulties of receiving guidance on teletherapy during the pandemic. After

some initial struggles, the overall experience providing teletherapy to early childhood populations were better than expected, especially for families who came from a different cultural-linguistic background from the SLP. The teletherapy format lent itself toward the SLPs incorporating more evidence-based approaches such as parent coaching and using items in a child's natural environment to expand their communication skills. The teletherapy schedule also made it more convenient for parents and caregivers to be involved in their child's intervention, limit SLP burnout from travelling, and also have access to virtual supports like interpreters. These are all contexts that can contribute to more positive intervention outcomes (Brown & Woods, 2015; Guiberson & Atkins, 2012; Laing & Kahmi, 2003). As a result, the clients experienced progress similar to in-person therapy. Therefore, the use of telepractice with early childhood populations may mirror or enhance the potential to provide evidence-based, culturally responsive services compared to in-person therapy.

Nonetheless, most participants felt that linguistic differences can still impact the communication and relationships they can build with the families they work with. Fortunately, as supported in prior literature, SLPs still recognize that it is primarily their responsibility to overcome communication barriers and build rapport with families (Guiberson & Atkins, 2012; Kohnert, 2013; Hile et al., 2016). Furthermore, if the SLP is highly culturally responsive, then intervention quality and progress for these families should be similar to clients from English speaking families. There are infinite factors to consider in determining treatment outcomes. However, despite positive treatment outcomes, SLPs who were not bilingual did feel less confident in providing intervention to families who spoke a different language. Interestingly, although the SLPs in this study had experience working with families from various linguistic background, they did not acknowledge major differences in their experiences working with

languages that has varying levels of linguistic distance compared to English (e.g. working with a Spanish speaking family vs. a Hindi speaking family). This is similar to previous studies on bilingual language research that did not address linguistic distance in their findings (Kapantzoglou et al., 2012; Thordardottir et al., 2015). So, awareness about the variation of minority language speakers and supports appears minimal, other than difficulties in finding translators when needed. For instance, Spanish resources, activities, books, etc. are more readily available in the U.S. than those in Hindi. Nonetheless, providing SLPs with additional supports while communicating with families who are culturally or linguistically different than the SLP may increase their confidence and effectiveness in working with these families.

Limitations

There are limitations that should be acknowledged in this study. First, the participants in this study knew the interview would be about cultural competency, so this might have influenced their willingness to participate (i.e., self-selection bias) as well as potentially influenced their responses to some questions (e.g., independently reading/learning about issues of cultural competency before the interview). Second, some participants conducted the Zoom interview at home, while others did it in their workplace. So, it is unclear whether this impacted the level of openness in sharing in their experiences. Third, consistent with the purpose, the study only explored SLP perceptions on their cultural competency and service delivery for CLU populations and did not measure the effectiveness of their practices, which could have provided further insight into their understanding of cultural competency.

Conclusions

This study underscores the need to increase SLPs knowledge in cultural competency, as well as their confidence, in providing services to CLU populations. The approaches and avenues

of educating SLPs on cultural competency are endless; however, future research on how to best engage SLPs is needed. While feeling uncomfortable is a natural part of difficult, but necessary, discussions, individuals teaching SLPs should be mindful of how to approach certain topics. If approaches are too aggressive, SLPs may become disinterested in future discussions or learning opportunities on cultural competency. Furthermore, exploration on the role of social media in enhancing awareness of cultural competency may reveal important insight into its role in the dissemination of research and information on best practices for cultural competency. Methods to increase cultural competence for SLPs should provide opportunities to participate in important discussions and reflection, while receiving knowledge that will increase their confidence in providing culturally responsive and sustaining services.

CHAPTER 3

PHASE 2: GRADUATE SLP STUDENT PERCEPTIONS ON CULTURAL COMPETENCY AND LINGUISTIC DIVERSITY

The American Speech-Language-Hearing Association (ASHA) and the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) require graduate programs to provide students opportunities to demonstrate cultural-linguistic competency as a component of clinical competency so they can better serve culturally and linguistically diverse individuals (CAA, 2018). According to ASHA, cultural competency is optimizing the assessment and treatment process for a client by appropriately understanding, appreciating, and responding to their cultural background. (ASHA, 2004). The importance of professional cultural competency is underscored by the diverse demographic profile of the United States and amplified by a need for providing services that are appropriate for each individual served. The following is an exploration of the current literature within speech-language pathology on graduate SLP education regarding cultural competency resulting in an outline of notable issues and recommendations. This information informs the methodology for a qualitative study exploring SLP graduate students' perspectives on cultural competency, particularly with culturally and linguistically underrepresented populations in early childhood contexts.

Scope of Practice

SLPs have a wide scope of practice that encompasses serving individuals with communication and swallowing needs across various ages, diagnoses, and settings. The scope of practice consists of both professional practice domains and service delivery domains (ASHA,

2016a). Professional practice domains include advocacy and outreach, supervision, education, administration/leadership, and research. Service delivery domains include collaboration, counseling, prevention and wellness, screening, assessment, and treatment. Although each domain focuses on a different aspect of practice, cultural competency is embedded in all domains. Therefore, the relevance of cultural competency can be applied and taught within various domains. For example, “multicultural/multilingual infused” courses within a curriculum can effectively provide individuals with a deeper understanding of cultural competency (Lubinski et al., 2008). Therefore, an understanding of how SLP programs educate students on cultural competency will provide a preliminary understanding of the kind of foundations students are receiving.

Educational Programs

In order to be eligible for the certificate of clinical competence (CCC), an SLP must graduate from a program accredited by CAA (CAA, 2017). The specific opportunities to learn about and build cultural competency at the graduate level depend on how the program meets the competency standards. The CAA acknowledges that Masters’ programs should provide graduate students with content knowledge and applied opportunities to demonstrate “attributes and abilities” of cultural competency as one of nine Professional Practice Competencies (CAA, 2017).

ASHA provides several evidence-based resources on their Multicultural Affairs and Resources Practice Portal for students and clinicians, such as self-assessments and resources for working with underrepresented populations (e.g., transgender voice, phonemic inventories, international adoptees) (ASHA, 2019c). Lubinski et al. (2008)’s guide on creating “multicultural/multilingual (MMI) infused” curriculums in university settings (e.g., sample

syllabi for different content areas) is also available. In Hammond et al. (2009), graduate program directors reported that these tools are sufficient in building students' cultural competency. However, the manner in which these resources are applied across programs vary (Quach & Tsai, 2017, Santhanam & Parveen, 2019). Deeper evaluation of resources and additional planning (e.g., creating the lectures) are necessary by faculty members and instructors especially since resources provided by ASHA should be considered as a superficial outline of information. Without added preparation, students may not feel prepared to work with minority populations or have a diverse caseload. For instance, in several studies SLPs, White monolingual-English speakers in particular, felt unprepared to work with CLU populations because of the lack of education within their graduate program. This can lead clinicians to feel inadequate and overwhelmed, which can contribute to SLP attrition in underserved areas (Farrugia-Bernard, 2018; Guiberson & Atkins, 2012; Santhanam et al., 2019; Trembath et al., 2016).

The development of professional cultural competence in SLPs is shaped by coursework, clinical placements, and mentorship experiences in graduate school (Cornish & White, 2016; Hammond et al., 2009; Howells et al., 2016). Suggestions of curriculum-wide approaches for fostering cultural competence in graduate programs are available via the ASHA Office of Multicultural Affairs (n.d.). the historically most popular being unit and course approaches (ASHA Office of Multicultural Affairs, n.d.; ASHA Committee on the Status of Racial Minorities, 1987; Walters & Geller, 2002). Stewart & Gonzalez (2002) caution that faculty and administrators integrate multicultural content in curricula in an orderly and meaningful fashion. ASHA curriculum approaches aim to provide students with a foundation in cultural competence that they are able to apply it varying clinical contexts. Therefore, it is crucial that curricular

content is not “peripheral to the understanding of communication sciences and disorders” (Walters & Geller, 2002).

There are several studies and initiatives that discuss the significance of cultural competency (Banerjee & Guiberson, 2012; Guiberson & Atkins, 2012; Hammond et al., 2009; Quach & Tsai, 2017; Santhanam & Parveen, 2019), but very few that consider and deeply explore the experiences of minorities within the profession, despite ASHA repeatedly expressing support for this need (Brook, 2012; Rodriguez, 2016). Increasing diversity within the profession may improve access quality of services for CLU populations, as well as consideration of diverse perspectives during intra professional and interdisciplinary collaboration. Furthermore, increasing diversity can be beneficial for all clinicians and clients in the field, not just those who are minorities (Walters & Geller, 2002).

Efforts, from minority clinicians have historically increased cultural competence within communication sciences and disorders. For instance, the development of the National Black Association of Speech Language and Hearing (NBASLH) in 1978 has garnered awareness of the needs of researchers, clinicians, and clients who are Black, racial minorities, and bi/multilingual language speakers (Reeves & Beverly-Ducker, 2008). Doing so has reduced disparities to minority clients, provided opportunities for minority professionals to connect, and highlighted future directions needed in research for underserved populations. Additional efforts include the annual ASHA Minority Student Leadership Program (MSLP) (ASHA, 1999), which fosters leadership qualities for minority students during a series of seminars and networking events offered during the ASHA convention. Through this program, students can network with minorities in the profession and build mentoring relationships that will give them a better understanding of how to (a) be successful in the field and (b) the importance of cultural

competency. Many alumni of the MSLP program have later obtained leadership positions within ASHA, the community, and academia that allowed them to increase awareness of cultural competency among others by acknowledging privileges in order to minimize biases (Deal-Williams & Johnson, 2012).

Biases

Greater awareness of how certain privileges (e.g., White privilege) create biases in practice can be used to build cultural competency for students, clinicians, and researchers (Farrugia-Bernard, 2018; Kathryn Kohnert, 2013; Preis, 2013). Therefore, decentering a particular group of individuals as what is standard or typical (i.e., the majority) could minimize generalizations about other groups (i.e., minorities). Nonetheless, texts commonly used by students may be unintentionally present stereotypes about particular populations which are not particularly meaningful and useful in practice. For instance, ignoring the complexity of certain racial-ethnic groups by providing lists of "cultural tendencies" from various racial-ethnic groups (Roseberry-McKibbin & Pratt, 2014). Instead of being culturally relative, some texts and resources may also compare and contrasts mainstream "American" beliefs and values to "other" cultures in a way that is ethnocentric (Roseberry-McKibbin & Pratt, 2014). It could be detrimental if this type of information is applied to clinical practice. These problematic approaches and resources may promote ethnocentrism and reinforce stereotypes by presenting cultural competency as a finite goal (Chang et al., 2012; Tervalon & Murray-Garcia, 1998). Other recommendations include encouraging students and clinicians to use cultural dimensions as a more individualized method to understanding one's culture (Hofstede, 2011). For instance, a more useful clinical approach would be to learn about a client and their family's personal views

within certain cultural dimensions (e.g., child-rearing practices, education, healthcare, family dynamics).

Problem Statement

There are increasing efforts to enhance knowledge and meaningful application of cultural competency for students pursuing degrees in communication sciences and disorders (Hammon et al., 2009; Quach & Tsai, 2017, Santhanam & Parveen, 2019). However, resources and instructional approaches to build students' cultural competency may not align with best practices, and graduate SLP students must consider the responsibilities they have regarding culturally competent service delivery to be strong clinicians. Therefore, exploring graduate student perspectives on cultural competency may help faculty members and researchers reevaluate evidence-based approaches and terminology used when teaching SLP graduate students on working with culturally and linguistically diverse populations. Furthermore, the results may inform the best ways to support SLPs in the areas of graduate education, continuing education, and ongoing research to enhance the equitability of services for clients from various cultural-linguistic backgrounds (ASHA, 2004).

Purpose and Research Questions

There is an ongoing need for research on how future clinicians are trained to provide services for CLU clients because this comes with its unique set of challenges and opportunities. Therefore, to identify how the new generation of SLPs are trained in cultural competency, it is essential to gain the perspectives of current graduate SLP students. The purpose of this study is to use a phenomenological approach to examine how SLP graduate students are trained to serve CLU young clients and families by exploring the following questions through a qualitative survey.

1. How do SLP graduate students define cultural competency and linguistic diversity?
2. What do SLP graduate students perceive as considerations for cultural competency during intervention (i.e., the diagnostic and treatment process) specific to young clients whose primary home language is not English?
3. How do SLP graduate students view the quality of courses, resources, or opportunities within their program that foster cultural competency for CLU populations?
4. How do SLP graduate students perceive the potential impact of a family's primary language on the professional relationship between the SLP and client as well as intervention outcomes?

Method

The methodology of this study is shaped by a phenomenology, which is grounded in the notion that the most appropriate descriptions regarding the fundamental structure of the phenomenon come from individuals who have experienced said phenomenon. (Van Manen, 2016). The structure discovered as a phenomenon is examined across time and diverse contexts or perspectives. A phenomenological approach is well suited for this study because the goals are to investigate commonalities among individual experiences (i.e., graduate SLP students) to describe a particular phenomenon (i.e., perceptions of graduate learning experiences about cultural competency and service delivery for CLU populations; Cresswell, 2013). This is designed to provide insight into graduate students' experiences on how education on cultural competency and service delivery for cultural and linguistic minorities is provided in order to gain

a more authentic understanding of this phenomenon of SLP graduate students' perceptions and experiences with cultural competency with CLU populations.

Reflexivity Statement

This study investigated current SLP graduate students' learning experiences and perspectives on cultural competency and service delivery for CLU populations. The author's investment in this topic comes from her identity as a speech-language pathologist, researcher, Hindu, Indian-American, and as a minority language speaker who speaks Gujarati, Hindi, and English. The author was also a Masters student in speech-language pathology within the past five years and has experience and interest in planning and participating in initiatives aimed to increase cultural competency among speech-language pathology graduate students and support for CLU students. These initiatives were inspired by the authors personal dissatisfaction and critiques of their exposure to cultural competency as a Masters student. However, the author did not have personal insight into the most current SLP Masters student experiences learning about cultural competency. As a result, the author decided to interview current SLP masters' students to gain the most authentic perspectives on cultural competency education at the graduate level. Nonetheless, the author's positionality influenced the essence of data collection and analysis, and also provided an additional lens of reflection on the data.

Participants and Setting

Recruitment of participants and implementation of the study began after obtaining approval from the institutional review board. Participants for this study included 12 students enrolled in graduate speech-language pathology programs. The aim of this study was to explore the perspectives of SLP graduate students in learning about cultural competency and service delivery for CLU populations within their respective US-based graduate education programs.

The interviews were conducted in English with US-based participants who are proficient in English. Participants were recruited online through information distributed via social media and university alumni listservs. Sampling approaches were mixed, with purposeful sampling (e.g., online groups specific to SLP graduate students) combined with convenience sampling (e.g., university student listservs). Snowball sampling (i.e., referrals by other participants) was also utilized to recruit more participants. Participants were selected for an interview on a volunteer basis and availability. Geographical location was also considered in an effort to gain diverse SLP perspectives (e.g., interviewees from different states and regions as opposed to one city). Zoom online video conferencing software was used to conduct interviews with participants on their laptops (Zoom Video Communications Inc., 2016). The flexibility of Zoom allowed for communication with participants in various geographical locations, and security measures such as encrypted sessions and meeting passwords made Zoom an appropriate research tool (Archibald et al., 2019). A total of 12 participants were recruited for this study because a smaller sample (i.e., less than 20 participants) allowed the researcher to form a closer relationship with participants by fostering more open dialogue during the interview, thus enhancing the validity of in-depth inquiry (Crouch & Mackenzie, 2006). A closer relationship and level of comfort was also maintained by the researcher's shared identity with the participants as a graduate student, as well as the researcher situating the participants as experts in their lived experiences as SLP graduate students. Data saturation was used to determine a sufficient number of participants to represent graduate student perspectives (Fusch & Ness, 2015). Once there were similar responses across participants, it was determined that there was enough data to move forward to analysis.

The participants ages ranged from 22 to 31 year, with the average being 23 years. All participants had a Bachelor's degree, and two had a Master's degree in an unrelated field. The

participants were in various stages of their Master's program, but half were in their first year and half were in their second year. Most participants were from Pennsylvania (n = 7), and the others were from Florida (n = 1), Georgia (n = 2), Massachusetts (n = 1), and New York (n = 1). Two were currently in fully online programs due to the COVID-19 pandemic, but the rest were in a hybrid program. One participant identified as Black/African-American, and the rest self-identified as White. Most participants communicated in English as their primary (and only) languages, but some participants knew American Sign Language, French, Spanish, and Yiddish. See Table 2 for demographic information of participants.

Procedures

Demographic information was first collected and tabulated via a Qualtrics survey (see Appendix C). Afterward, the interviews were conducted in English with the primary researcher as the interviewer. The interviews were semi-structured and approximately 30-45 minutes. All interviews were audio recorded for later transcription and analysis. Interviews took place via Zoom at the most convenient time for each participant. A set of open-ended questions was used to guide the interviews (see Appendix D). These questions explored participant views on cultural competency and linguistic diversity, educational experiences learning about cultural competency, and the impacts of language on a clinician's relationships with clients and intervention outcomes.

Data Analysis

The themes found in the data were identified, analyzed, organized, and described with a thematic analysis (Braun & Clark, 2006). The data analysis process involved three phases as described in Nowell et al., (2017): (a) familiarization with the data; (b) generation of initial codes; and (c) exploration for themes (see Figure 3).

Phase 1 involved transcription of audio recordings on a word processing document, then later uploaded to the qualitative analysis computer software program NVivo (Bazeley & Jackson, 2013). The entire data set was read at least twice following transcription and before coding in order to identify possible patterns and coding ideas that were revisited in Phase 2, when initial codes were generated. During this process the data was simplified, indexed, and labeled in specific and larger categories as they related to themes. Coding approaches were documented throughout the data analysis process. Some codes included cultural-linguistic background, coursework, and navigating barriers. Phase 3 began after the initial coding of data. In Phase 3, all relevant coded data was organized into themes that linked and described significant components of the data.

This method of deriving themes was inductive because patterns within the data were examined to create descriptions for these observations (Braun & Clarke, 2006). These themes were examined to determine how they possibly addressed our research questions as well as what conclusions could be drawn.

Trustworthiness

Several procedures were planned to ensure the trustworthiness of the findings. In the design stage of the study, the plan and methodology were peer-reviewed by four experienced researchers to increase methodological rigor leading to strength in the findings. Member checks were conducted during the interviews so participants had the opportunity to clarify their responses and ensure that the data were an accurate portrayal of the participants' views. The research team reviewed audio recordings and subsequent transcriptions of the interviews for consistency. Finally, transcripts, emerging and final codes, themes, and findings were reviewed

and evaluated by multiple peer researchers to enhance the credibility of the findings (Janesick, 2007).

Findings

Three major themes were formed from the data: consistency and variation, limited educational experiences, and anticipated barriers. These themes illustrate the lived experience of the participating graduate students related to their perspectives of learning about cultural competency and service CLU populations through their graduate education program.

Theme 1: Consistency and Variation

Most participants spoke about cultural competency in a way that is consistent with ASHA's definition: an ongoing process that includes both awareness and humility. Participants also emphasized the importance of not making assumptions about a family's beliefs. However, there were some participants who were highly critical of the term "cultural competency" because they believed that it was semantically inappropriate, misleading, and may promote a false sense of security:

> *I think cultural competency is a trashed term because we're never fully competent, it's not a thing that you're ever dealt with. And especially as a white female it's something I will always be reevaluating as I grow as a clinician...I actually prefer the term cultural responsivity (Participant 2)*

These participants explained that the term "cultural competency" appears arbitrary, and other terminology such as cultural humility, cultural sensitivity, or cultural responsivity should be used instead because it is semantically appropriate and better captures the essence of the process:

> *I actually prefer cultural sensitivity or cultural humility instead of cultural competency, because to me being competent in a culture is something that you can't achieve 100%,*

whereas being culturally sensitive it makes a little bit more sense to me, cause I'm able to check my bias and step out of your comfort zone and acknowledge that not everyone has your same views, beliefs, language, or ability… people do things differently than you and you have to be okay with it. (Participant 4)

However, all participants described linguistic diversity similarly, and interpreted it as acknowledging the language variation that exists among different people and being cognizant of it when providing services to clients. For instance, understanding the linguistic practices of clients and fostering preservation of their native language:

I would want to make sure that they know to continue speaking their language. It does not hurt speaking their heritage language to their child because it is no way causing a disorder. If anything, if you were to stop speaking that language, it would be more detrimental. (Participant 2)

Participants also made connections between cultural competency and linguistic diversity and how they influence one another. They acknowledged that cultural competency is especially important when working with early childhood populations because it sets the foundation for language experiences later on in life:

I think being culturally competent is important for especially for young kids, because they're just starting to develop language. And the more that you're able to be competent with different cultures and different languages in general, the better care they're going to receive and the more, language rich opportunities they're going to have access to. (Participant 3)

No participant felt fully confident when discussing their perceived level of cultural competency. As students, they felt their graduate experiences made them realize how much they do not know

and felt they will learn more with additional clinical experience. They believe that practicing clinicians and individuals living in diverse areas are likely to know more about cultural competency:

> *I would say that I need to definitely understand more cultures better. My area has never been very culturally or linguistically diverse, so I need to do more research of other cultures because I won't live here forever…I could come in contact with more [cultures or languages] if I were to move to a bigger city, more populated city. Just so that I understand the clients that I could see. (Participant 1)*

Although participants felt their cultural competency was still limited, they all had varying opinions about the term cultural competency, with some more critical of it than others.

Theme 2: Limited Educational Experiences

Requirements for cultural competency differ across graduate programs, so the educational experiences of students also varied. Some participants felt their exposure to cultural competency during their graduate program was adequate, and experienced at least some growth in knowledge, while others felt it was lacking. For those who had positive educational experiences, it was because they learned information in their graduate program that they did not know before. Intentional inclusion of cultural components within specific pedagogical approaches, such as problem-based learning, were discussed as supporting development of cultural competence:

> *It's been awesome. So, I know our program they're a little bit different, we do problem-based learning, so we get a different case each week and then we work through the problem and we look at different aspects throughout the week. We always have a cultural*

component in there. So even if our case is, you know, a monolingual student, we always look into other cultural situations. (Participant 8)

Participants also expressed that although they were made aware of the lack of diversity in the field, there is still more they would like to learn in their programs through hands-on learning opportunities and discussions. Two students mentioned having optional electives on multicultural issues, whiles others mentioned it briefly in their courses. One participant shared that student of color especially felt the need to independently seek opportunities to learn about cultural competency and bi/multilingual service delivery, whether it be through social media or initiatives they created within their own programs:

I kind of have to learn on my own and like, given that I'm one of the few persons of color in the program, I'm constantly pushing for us to have these conversations…one of the things that my cohort got sick and tired of was this small amount of talking and conversations about cultural competency or sensitivities. So, we decided to create a spreadsheet of resources per class that we've taken. (Participant 4)

Some participants also felt that their professors may not be suited to teach them about cultural competency. They provided examples of problematic approaches used in teaching and insensitive comments made about different cultural-linguistic backgrounds. These issues also negatively impacted the rapport and level of trust they built with their professors:

We've had some issues actually…in our multicultural class we were required to do an ethnographic interview where we interviewed somebody from a different culture and one of the professors said that if you couldn't find anybody from a different culture to interview, you could just go down to the local Mexican restaurant and probably find

> *somebody there. And so that was a huge ordeal…and this same professor actually asked a student if she was legal in her class. (Participant 12)*

A new context for culturally competent service delivery for many graduate programs was introduced during the COVID-19 pandemic, which was the participants' first exposure to telepractice. Although a few preferred in-person therapy, most had a positive experience with telepractice. They enjoyed the convenience of this approach and were mostly understanding of their professors' challenges in teaching their students. They also saw the applicability of telepractice to coach caregivers of their clients of various cultural and linguistic backgrounds. However, they wish they would have received more resources on telepractice, and were unsure how much of their instruction translated to telepractice:

> *I wish that we would have had more guidance from our professor on how to do the evaluation through teletherapy, because obviously she was teaching it from like an in-person perspective because it was a recorded lecture, from previous semesters and it wasn't really targeted to the pandemic and the additional stressors that everyone else is having with the pandemic. (Participant 7)*

Most students were understanding about their professor's limitations and their responsibility as students to learn content about cultural competency and service delivery for CLU clients. they believed that they should be receiving more guidance and meaningful opportunities to learn about how to apply it in clinical practice. Students more open to critiquing their professors and programs were also more aware of their lack of knowledge in certain areas.

Theme 3: Anticipated Barriers

Because the participants were graduate students, they discussed what they think SLPs may experience when working with families from a different linguistic background. Most

believed that working with families with a different language background may present some challenges in building rapport due to communication barriers, especially when working with families with young children. Also, linguistic differences may make situations more challenging compared to cultural differences:

> *I think working with someone that has a completely different language than me is probably harder than working with someone who has a different culture…But I think that the different language really throws in a wrench. (Participant 7)*

Despite the perceived challenges that may come with language differences, most participants shared that building rapport with families primarily depend on the SLP's own level of cultural competence. Some believed the family's own cultural beliefs may be a large factor in influencing their view towards the intervention process, and subsequently their relationship with the SLP:

> *I think it definitely has a lot of different ways it could impact it... One of the most interesting ways was maybe the family's view on disability… or how the family structure is. If they are very tight knit or not and how that can affect communication. (Participant 11)*

Responses were mixed when it came to the participants view of how an SLP's relationship can impact the intervention quality and progress for families who do not speak English as a primary language. Most believed that treatment quality and outcomes depend on the SLP's cultural competence, while some thought that the impact of lack of communication barriers may be too strong.

> *It would probably hinder the progress if there's all that tension [in communication] and the therapist isn't using their skills to the best of their ability due to those differences and any pushback that could be from the family side or the clinician side. (Participant 7)*

Overall, some participants believed that cultural and linguistic barriers form inherent limitations when it comes to building rapport with clients, intervention quality, and treatment outcomes. However, there were many who believed that ultimately, it is an SLP's responsibility to build their own cultural competency in order to successfully navigate cultural and linguistic differences.

Discussion

The purpose of this study was to explore the lived experience of Master's students in speech-language pathology programs related to learning about professional cultural competence. The themes that came from the data provide insight into strengths and areas of growth for graduate programs in meeting standards of cultural competency. The students' shared and divergent perspectives align with the variability across the field. This discussion will further describe the findings with specific relation to research and current practice patterns as well as discuss implications and future directions.

Terminology

The graduate student participants' definitions and critiques of the terminology used to describe cultural competency align with current discussions and tensions of how terms are applied. Overall, graduate students define cultural competency similarly: an ongoing process that involves awareness, humility, and not making assumptions about a client's family's beliefs. This is consistent with the definition that ASHA provides about cultural competency and suggests that there are consistencies across the participants' graduate programs on how they teach students about cultural competency. However, some participants were very critical of the term "cultural competency" and believed that terms like "cultural humility," "cultural sensitivity," or "cultural responsivity" were semantically more appropriate. The participants shared that the term "cultural

competency" may indicate that there is an end goal of being fully competent and undermines that it is an ongoing process. These critiques of the term "cultural competency" are consistent with previous discussions of the term not appropriately capturing the ongoing goal of cultural sensitivity, responsivity, and humility, and how individuals many misinterpret "cultural competency" as a finite objective (Chang et al., 2010; Danso, 2018; Fisher-Borne et al., 2015; Greene-Moton & Minkler, 2020; Paris & Alim, 2014).

This study was the first time most participants were exposed to the term "linguistic diversity." All described the term as a variation in linguistic backgrounds, and many made the connection between linguistic diversity and cultural competency, and how clinicians should be aware of their client's linguistic backgrounds when planning and providing assessment and intervention. Linguistic considerations are a fundamental component of cultural competency. The participants described their perceived level of cultural competency as limited, primarily because they are graduate students and have more to learn as they grow as a clinician. Students attending programs in less diverse areas believed that they will further develop their cultural competency once they move to a diverse area as a clinician.

Some participants believed they were receiving a strong foundation in learning about cultural competency within their graduate program, while others believed that exposure was minimal, especially for serving bi/multilingual populations. These varied experiences are consistent with the notions that implementation of clinical standards vary across graduate programs, particularly for cultural competency (ASHA, 2019a, CAA, 2017). However, this variation in experiences would be concerning if it correlated with disparities in the actual quality of graduate education on cultural competency, which was not the purpose of this study.

Personal and Professional Competency

Participants who had prior, personal experiences reflecting on cultural-linguistic diversity were more critical of their programs than those who did not (e.g., Participants 2 and 4). For example, students who belonged to communities on social media that discussed cultural competency. This was probably because certain participants were aware of the vast amount of resources and knowledge available on multicultural considerations and issues. There are also participants who did not trust their professors to teach them about cultural competency because of their problematic approaches and comments made regarding CLU populations (Participants 7 and 12). As a result, many participants expected themselves to learn about cultural competency independently or in their post graduate professional career. Some even create their own initiatives to build their cultural competency, including bi/multilingual populations, within their programs by compiling resources with classmates or coordinating guest lectures (e.g., Participants 2 and 4). Although it may be admirable to see increased awareness of cultural competency, it can also be concerning that students feel their graduate education alone is inadequately preparing them to be culturally competent clinicians, particularly for clients who are bi/multilingual and/or linguistically underrepresented. Therefore, the students who are less critical of their programs, and perhaps less aware of multicultural issues, may be less inclined to educated themselves beyond the scope of their program.

Experiences with Telepractice

Participants viewed providing telepractice during COVID-19 pandemic as any other new learning experience they may across in their graduate program. However, they had to navigate and learn with their professors. This reflects previous research that shows limited instruction of telepractice across graduate programs as well as limited understanding of telepractice by faculty

and students (Grogan-Johnson et al., 2015; Overby et al., 2017). Although many enjoyed the convenience of telepractice and were understanding of their professors' limited knowledge in this area, participants were unsure how to apply what they learned through telepractice to real life. They could see the relevancy of telepractice for early childhood populations because it encouraged more evidence-based practices such as increased parent involvement and coaching (Brown & Woods, 2015; Guiberson & Atkins, 2012; Laing & Kahmi, 2003). However, students were unsure how they could apply what they learned to an in-person client. This is especially since some of them had their first young client via telepractice. So, more instruction regarding the relevancy between telepractice and traditional, in-person practice would be helpful for graduate students.

Language Barriers

Most participants felt that linguistic differences could potentially impact the communication and relationships they can build with client and their families, especially within early childhood contexts. Although, the participants acknowledged that it is primarily the clinician's responsibility to overcome communication barriers and build rapport with families, which is consistent with prior research on recommended practices (Guiberson & Atkins, 2012; Kohnert, 2013; Hile et al., 2016). Some participants believed that the intervention quality and progress for linguistically underrepresented families may be limited. However, others believed that all clients have the potential for optimum quality of intervention and progress as long as the SLP has a high level of cultural competency, which is consistent with previous findings on enhancing services for underrepresented populations (Guiberson & Atkins, 2012; Kohnert, 2013; Hile et al., 2016). So, the participants had a positive outlook on the great benefits of being culturally competent. Although students acknowledge the variation of linguistic diversity earlier

in their interviews, they did not acknowledge considerations when working with families who speak languages with varying levels of linguistic distance compared to English (e.g. working with a Spanish speaking family vs. a Hindi speaking family). So, it seems that there is minimal awareness about the variation of minority language speakers and the issues they face regarding access to resources, cultural-linguistic preservation, etc. This is consistent with the lack of research regarding limitation of resources for minority language speakers (Santhanam et al., 2018) However, since the participants believed their knowledge on cultural competency was minimal, they may be responsive when learning about this topic and other cultural-linguistic considerations not discussed in their programs.

Limitations

There are some limitations that should be acknowledged in this study. First, the participants in this study were aware that the interview would be about cultural competency, so it is uncertain whether this impacted their responses to questions. Also, the study only explored graduate student perceptions on cultural competency and personal experiences in their programs, but did not measure the actual quality of their graduate programs' approaches to education on cultural competency.

Conclusions

This study highlights the strengths and weaknesses of current graduate programs in educating students on cultural competency. Most of the participants in this study were open to constructively critiquing their programs, engaging in self-reflection outside of their program, and independently making connections that are not explicitly taught. However, varying experiences learning about cultural competency are consistent with the notion that curricular requirements are generally at the discretion of the graduate program. Nonetheless, further exploration into the

quality of SLP graduate education on cultural competency is necessary in order to identify inconsistencies across programs. Doing so may help determine the best approaches to enhance consistency in quality of education on cultural competency. Overall, more opportunities to learn about and discuss cultural competency, as well as more consistent approaches across programs, may minimize disparities in cultural competency among students and generate stronger clinicians.

CHAPTER 4

CONCLUSION

Exploring speech-language pathologists (SLPs) and SLP graduate students' experiences and perspectives about learning opportunities, knowledge, and exposure to professional cultural competency contribute to the ongoing goals of expanding: (a) knowledge and application of cultural competency; and (b) current and future speech-language pathologists ability to best serve CLU populations. This research is one of the first that specifically explored experiences and perceptions of SLPs working with early childhood populations and graduate students who are being prepared to work with young children to better understand the specific considerations for CLU clients within these populations. Focusing on SLPs and graduate students in separate studies provided an in-depth exploration of each participant groups' experiences. Additionally, exploring themes across the studies can provide insight into how professional training opportunities supplement graduate education and how much graduate education on cultural competency and service delivery for CLU clients have evolved over time.

Overview

The importance of professional cultural competence is underscored by the need for providing relevant individualized services for each individual served along with the continual diversification of the population. ASHA has promoted cultural competency efforts to enhance the quality of services provided to underrepresented populations (ASHA, 2004; ASHA, 2008; Klingner et al., 2005). Although there is a growing awareness of cultural competency among SLPs, White individuals (92.2%) and monolingual English speakers (93.2%) make up the

majority of SLPs. Also, minority clients typically do not share the same racial-ethnic background as their SLP (Guiberson & Atkins, 2012; Reeves & Beverly-Ducker, 2008). Furthermore, there is little information available about the cultural-linguistic variation among members, which limits understanding of how well or how divergent the alignment is between the professionals and the individuals being served. The majority of instruction on cultural competency can be received through graduate school and continuing education opportunities (Stewart & Gonzalez, 2002; Walters & Geller, 2002; Lubinski et al., 2008; Cornish & White 2016). Therefore, information about learning experiences in cultural competency from SLPs and graduate students provides valuable information on positive trends as well as areas of improvement.

Study 1

In Study 1, 10 SLPs working with early childhood populations revealed their own perceptions and training received on cultural competency and working with CLU clients. The participants provided a definition of cultural competency that aligns with ASHA's definition (ASHA, 2004), which demonstrates that these early childhood SLPs had a similar understanding of cultural competency. They also recognized the role that linguistic variation may have when planning intervention. They consistently reported having minimal education on cultural competency and CLU populations inn graduate school. They described in-service learning opportunities to build and supplement their knowledge through professional training, continuing education, and hands-on experience. The reliance on educational opportunities after graduation highlights both encouraging and concerning aspects. On one hand, high-quality professional learning opportunities support the ongoing nature of continual learning and provide opportunities for current information and perspectives to be diffused throughout the profession. Alternatively, if SLPs are expected to independently supplement their knowledge, there are potential concerns

on how, when, and what information they may choose to learn. Additionally, there are potential concerns related to the approach used in professional development. The SLPs described that the approach of certain training opportunities from their employers to be more aggressive than supportive. There is a delicate balance in recognizing that the process of increasing cultural competence through cultural humility often requires discomfort while also not being too aggressive which may turn SLPs away from be interested in seeking additional knowledge on cultural competency.

Aligning with culturally competent service delivery, the participants in Study 1 acknowledged the responsibility of SLPs in building rapport with clients and providing optimum intervention services to achieve the best possible outcomes for their clients, particularly those who do not speak English as a primary language. SLPs should continue to explore educational and self-reflective opportunities on how to best navigate cultural and linguistic differences and communication barriers. Although the participants demonstrated a mutual understanding of linguistic diversity, the lack of resources available for minority languages (e.g., Hindi) compared to other non-English languages (e.g., Spanish) and the resulting challenges were not discussed.

Study 2

In Study 2, 12 graduate students discussed their own perceptions and current graduate education experiences in learning about cultural competency and working with CLU populations. Similar to the professionals in Study 1, the graduate students provided a cultural competency definition that is similar to ASHA's definition. This implies that there may be surface-level consistency among graduate programs on how cultural competency is introduced – at least across the graduate programs represented by the graduate student participants. However, some participants were critical of the term "cultural competency" because of concerns that the term is

misleading and suggests a finite goal. This issue of terminology is current within the field of speech-language pathology and related educational, clinical, and health services (Greene-Moton & Minkler, 2020; Hall & Johnson, 2020; Stubbe, 2020). Participants sharing the view of preferred terms such as “cultural responsivity,” “cultural humility,” or “cultural sensitivity” as more semantically appropriate and better representation of the intent behind the term “cultural competency” as described by ASHA. This perspective parallels those of scholars who critique the term “cultural competency” for not adequately representing the variation of cultural characteristics and the boundless nature of cultures (Chang et al., 2010; Danso, 2018; Fisher-Borne et al., 2015; Paris & Alim, 2014).

The graduate students associated linguistic diversity with linguistic variation and made relevant connections between linguistic diversity and cultural competency. Experiences learning about cultural competency in their graduate program were mixed, with some being satisfied and others critiquing their programs and professors for not providing sufficient guidance or knowledge. Solid foundational knowledge and learning opportunities at the graduate education level are important for future professionals in providing effective service delivery and to have the necessary context for supplementing and expanding their cultural competency knowledge as practicing clinicians (Stewart & Gonzalez, 2002; Walters & Geller, 2002; Lubinski et al., 2008).

Study 2 participants discussed that cultural and linguistic differences may make clinician-client rapport, high treatment quality, and best outcomes inherently difficult to achieve in early childhood populations. In contrast to the practicing SLPs, the graduate students did not discuss the potential added challenges of working with families who come from underrepresented linguistic backgrounds. However, they shared the perspective that it is ultimately the SLP’s

responsibility to build rapport with clients and provide optimum intervention services through culturally sustaining practices to achieve the best possible outcomes for their clients.

Implications

There were several similarities in the finding between Study 1 and Study 2. First, both SLPs and graduate students have a similar understanding of the term “cultural competency.” Participants in both studies also associated level of cultural competency with geographical location (i.e., living in a diverse area provides natural opportunities to increase cultural competency). Furthermore, although graduate programs seemed to have made improvements in their approaches to cultural competency and serving CLU populations, there are still many students who are unsatisfied with their educational experiences which is similar to SLPs who are currently practicing. Both groups mentioned the use of social media and other resources to strengthen their understanding, but it is unclear how they can assess the quality of these resources.

There were also interesting differences in responses between participants in Study 1 and Study 2. First, SLP participants viewed themselves to have a satisfactory level of cultural competency, with room to grow; whereas students rated themselves to have a low level of cultural competence because they are early in their career. Graduate student participants were more critical of the terminology and semantics of the term “cultural competency” than SLP participants. Lastly, SLP participants were more optimistic of being able to successfully build rapport and see positive treatment outcomes in families with language differences, whereas graduate students were more wary. These differences may be a factor of increased cultural competency education and opportunities provided currently in graduate school. If the graduate students are presented with learning experiences that represent the true complexity and ongoing

process of cultural competency, it is can be presumed that they would see themselves as needing to learn and experience more. Alternatively, these differences may be explained by a difference in direct experience. This is opposed to a finite list of stereotypical skills and practices that were historically presented to students to use when interacting with individuals from cultures outside their personal frame of reference (Roseberry-McKibbin & Pratt, 2014). Practicing SLPs have likely had more opportunities than graduate students to serve individuals representing a range of cultural and linguistic backgrounds.

Theoretical Frameworks: A Deeper Exploration

This dissertation served as a preliminary investigation into current early childhood SLP and SLP graduate student perceptions on cultural competency. Basic qualitative methodological approaches were used to explore the research questions in both studies. However, a richer exploration of this topic area could be pursued by the application of a richer and more comprehensive application of qualitative methodology. In particular, the use of a theoretical framework would center the inquiry in a way that would support greater meaning-making. A theoretical framework helps researchers navigate the research process by offering a “lens” through which certain phenomenon can be examined (Korstjens & Moser, 2017). For example, the focus of this dissertation centered on perspectives on serving CLU clients from the view of language being inherently tied to culture. Therefore, a theoretical framework that may be used for a future expansion of this topic could be rooted in language ideologies.

Language ideologies has been broadly defined as shared beliefs and perceptions about languages in their social experiences (Rosa & Burdick, 2017). When explored, language ideologies can reveal relationships between the beliefs individuals have about language and the broader socio-cultural systems they are members of, and how certain beliefs can be influenced

by and grounded within these systems (Schieffelin, 1998). As a result, language ideologies connect and shape the implicit and explicit assumptions regarding social, political, historical, and economic experiences and interests (e.g., colonization) (Bhattacharya, 2017).

Language ideologies as a theoretical framework may align with this topic if the purpose would be to further, and more specifically, explore SLP and SLP graduate students' beliefs about linguistic diversity, how these beliefs are shaped, and how it impacts their clinical practice. Furthermore, the use of theoretical frameworks like language ideologies may garner increased ideological awareness and, in turn, a direction towards more culturally responsive service delivery (Kiramba, 2018). Doing so may also move towards enhancing the rigor of research about cultural competency and other areas in communication sciences and disorders.

Future Directions

Future research should investigate the role that graduate programs play in fostering cultural competency and to what extent students and SLPs should take in educating themselves on cultural competency and working with CLU populations. Participants in both studies felt their cultural competency was limited because of their limited personal experiences of living or practicing in culturally and linguistically diverse communities. So, further research should explore how clinicians can develop their cultural competency and appreciate the variation within culture while practicing with seemingly minimally diverse populations. Additionally, continued research and advocacy efforts on increasing the cultural and linguistic diversity of SLPs within the profession is important. Researchers should continue to make research more accessible to clinicians by collaborating with them and considering which spaces and contexts clinicians are likely to connect and exchange knowledge with one another. For example, using social media to disseminate a more easily digestible version of research findings to expand implementation of

the latest recommended practices. Additionally, a future follow-up study with the participants in Study 2, once they become practicing clinicians, can provide future insight into how graduate education and perceptions on cultural competency have changed with the new generation of SLPs. Also, how perceptions on cultural competency can change over time. Furthermore, grounding inquiry with a sound guiding theoretical framework can lead researchers into a deeper exploration of the topic. Expanding this line of research exploring cultural-linguistic considerations in the context of early childhood speech-language with application of different research methodologies to the context of other age groups/treatment populations (e.g., adult neurogenic disorders) or with other professions (e.g., occupational therapy) can provide insight into the unique considerations for different groups and professionals.

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Table 1.

Demographic Overview of Early Childhood SLP Participants

Participant	*Age Bracket*	*Gender*	*Education*	*Experience*	*Employment status*	*Work Settings*	*Location*	*Race/ ethnicity*	*Languages (other than English)*
1	35-44	Female	Masters	11-15 years	Full-Time	Home, Daycare, Other	Georgia	Black or African American	Spanish
2	25-34	Female	Masters	5 years or fewer	Full-Time	Home, Daycare, Preschool, Telepractice	Texas	White	-
3	25-34	Female	Masters	5 years or fewer	Full-Time	Preschool	Texas	White	Sign language
4	25-34	Female	Masters	6-10 years	Part-Time	Home, Daycare	Arkansas	White	Spanish
5	25-34	Female	Masters	5 years or fewer	Full-Time	Home, Preschool, Elementary School	Colorado	White	Spanish
6	25-34	Female	Masters (Doctoral student)	6-10 years	Full-Time	Home, Daycare, Preschool	DC and Maryland	Hispanic-White	Spanish
7	45-54	Female	Masters	16-20 years	Full-Time	Preschool, Clinic, Telepractice	Texas	White	-
8	25-34	Female	Masters	6-10 years	Full-Time	Home, School board and private practice	Quebec, Canada	South Asian	French
9	25-34	Female	Masters	5 years or fewer	Part-Time	Private practice	Virginia	White	Spanish but not fluent

10	25-34	Female	Masters	5 years or fewer	Full-Time	Preschool	Illinois	White and Hispanic	Spanish

Table 2.

Demographic Overview of SLP Graduate Student Participants

Participant	***Age in Years***	***Gender***	***Education***	***Semester***	***Location***	***Race***	***Languages (other than English)***
1	22	Female	Bachelors	2nd semester	Georgia	White	-
2	24	Female	Bachelors	4th semester	New York	White	Yiddish, French
3	26	Female	Bachelors	5th semester	Pennsylvania	White	-
4	23	Female	Bachelors	3rd semester	Massachusetts	Black or African American	Spanish, French
5	23	Female	Masters	2nd semester	Pennsylvania	White	-
6	23	Female	Bachelors	2nd semester	Pennsylvania	White	American Sign Language
7	23	Female	Bachelors	5th semester	Pennsylvania	White	-
8	31	Female	Bachelors	5th semester	Pennsylvania	White	-
9	23	Female	Bachelors	5th semester	Pennsylvania	White	-
10	23	Female	Masters	1st semester	Florida	White	-
11	28	Female	Bachelors	2nd semester	Pennsylvania	White	Spanish
12	22	Female	Bachelors	2nd semester	Georgia	White	-

Table 3.

Study 1 Coding and Themes for Interviews with Early Childhood SLPs

THEMES	CODES	EXAMPLE
Consistency in Terminology	Defining cultural competency Defining linguistic diversity	*I would define it as an understanding, a sensitivity, and awareness to different cultures… Understanding and being sensitive and knowledgeable about their values (Participant 1)*
Personal Background and Cultural Competency	Cultural background Linguistic background Level of cultural competency	*Cultural competency was easy for me to grasp because of where I was born and raised… based on my background, my personal background or my experience, I would probably rate to be a little bit higher than most of my colleagues. (Participant 2)*
Seeking learning opportunities	Continuing education Graduation education Critiques of workplace	*In grad school... man, I feel like... I mean, did we have a lecture... is what I would probably guess. I don't even... [sighs]... it was limited. We'll just say that. I feel like people probably touched on it as, like, a talking point, you know, one time in this class and maybe there was one lecture in another class, but I don't feel like... there was much, like, direct instruction or teaching on it. (Participant 5)*
Diving into Telepractice	COVID-19 Telepractice Telecommunication	*I actually have, um, better family involvement from some of my families …[than] before the pandemic… I switched to more of a consultation model…And some of my kids actually really improved that way. (Participant 6)*
Clinician-Client Communication	Communication barriers Rapport Treatment outcomes	*I always want to be very approachable and nice…I'm still going to be myself. I'm going to be the, you know, bubbly, loving, wonderful clinician that I am to that family. That's not going to change. (Participant 11)*

Table 4.

Study 2 Coding and Themes for Interviews with SLP Graduate Students

THEMES	CODES	EXAMPLE
Consistency and Variation	Defining cultural competency Defining linguistic diversity Cultural-linguistic background Level of cultural competency	*I actually prefer cultural sensitivity or cultural humility instead of cultural competency, because to me being competent in a culture is something that you can't achieve 100%, whereas being culturally sensitive it makes a little bit more sense to me, cause I'm able to check my bias and step out of your comfort zone and acknowledge that not everyone has your same views, beliefs, language, or ability… people do things differently than you and you have to be okay with it. (Participant 4)*
Limited Educational Experiences	Coursework Clinical experiences Critiques	*I kind of have to learn on my own and like, given that I'm one of the few persons of color in the program, I'm constantly pushing for us to have these conversations…one of the things that my cohort got sick and tired of was this small amount of talking and conversations about cultural competency or sensitivities. So, we decided to create a spreadsheet of resources per class that we've taken. (Participant 4)*
Anticipated Barriers	Rapport Navigating differences Outcomes	*I think working with someone that has a completely different language than me is probably harder than working with someone who has a different culture…But I think that the different language really throws in a wrench. (Participant 7)*

Figure 1.

Qualities of a Culturally Competent Clinician

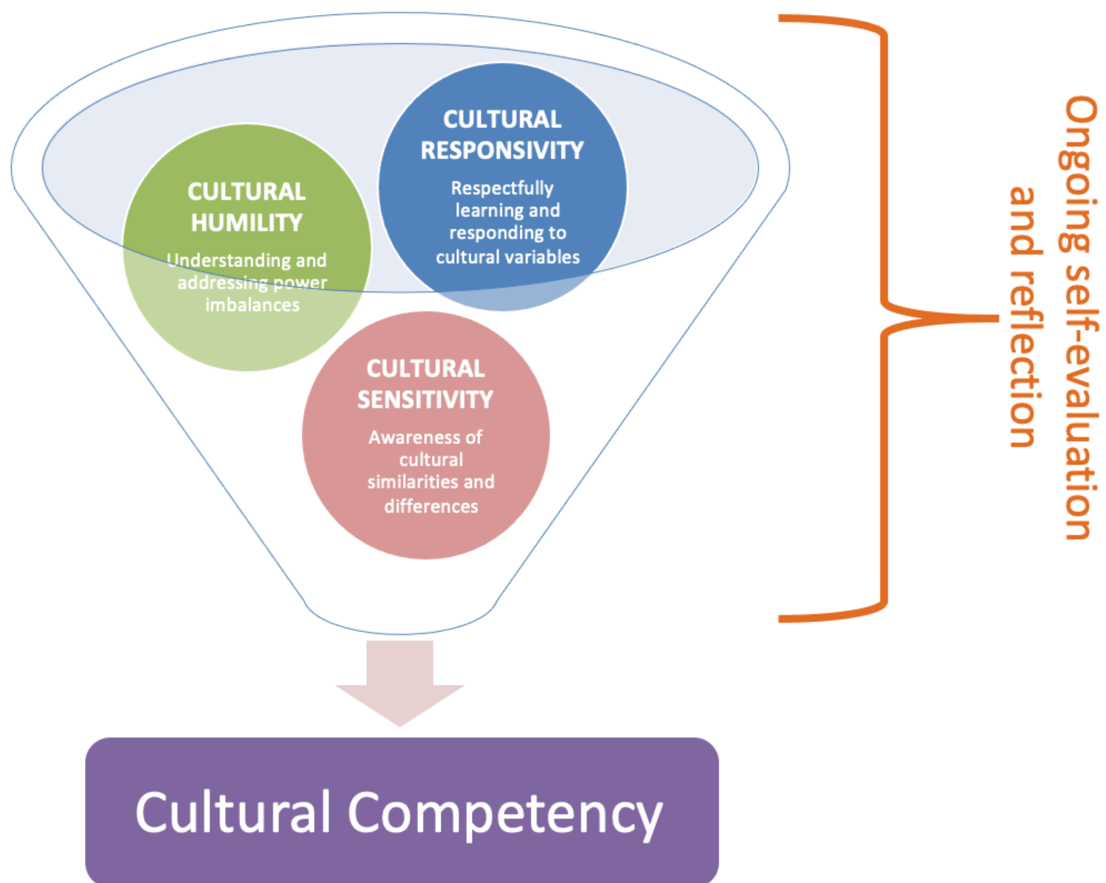
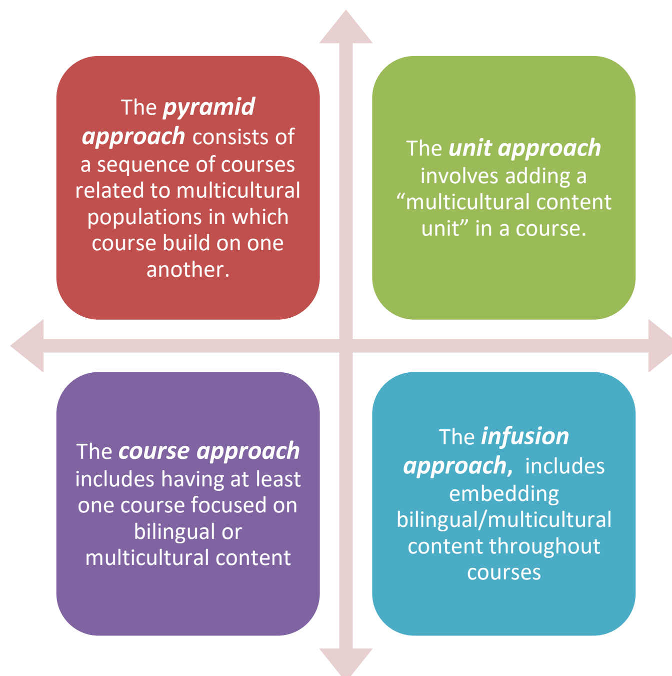


Figure 2.

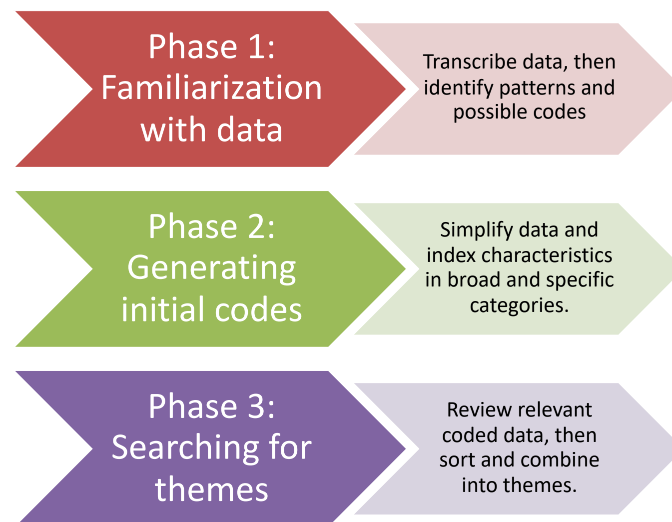
Multicultural Professional Education in Communication Disorders: Curriculum Approaches



(American Speech-Language-Hearing Association Committee on the Status of Racial Minorities, 1987; Walters & Geller, 2002)

Figure 3.

Phases of Thematic Analysis



(Braun & Clark, 2006; Nowell et al., 2017)

APPENDIX A

Early Childhood SLP Demographic Questionnaire

Q1 What is your age?

24 or younger (1)

25-34 (2)

35-44 (3)

45-54 (4)

55-64 (5)

65 and older (6)

Q2 I identify my gender as:

Male (1)

Female (2)

Non-binary/Genderqueer (3)

Other (please specify) (4) ____

Q3 What is your highest degree of education?

Bachelors (1)

Masters (2)

Research Doctorate (3)

Clinical Doctrate (4)

Q4 How many years have you worked as an SLP?

5 years or fewer (1)

6-10 years (2)

11-15 years (3)

16-20 years (4)

More than 20 years (5)

Q5 What is your employment status?

Part-Time (1)

Full-Time (2)

On Leave of Absence (3) Unemployed/Seeking Work (4) Unemployed/Not Seeking Work (5) Retired (6)

Q6 Are you currently a student? If yes, what program are you in?

No (1)

Yes, Research Doctorate (2)

Yes, Clinical Doctorate program (3)

Yes, other (please specify) (4) ____

Q7 What settings do you work in?

▢ Home (1)

▢ Daycare (2)

▢ Preschool (3)

▢ Other (4) ____

Q8 What state(s) do you work in?

____

Q9 What racial-ethnic background do you identify as?

- ▢ White (1)
- ▢ Black or African American (2)
- ▢ Native American (3)
- ▢ Asian (4)
- ▢ Pacific Islander (5)

- ☐ Other (6) ____

Q10 Did you speak any languages other than English

No (1)

Yes, please specify (2) ____

Q36 Do you understand any languages other than English?

No (1)

Yes, please specify (2)

APPENDIX B

Semi-Structured Interview Questions for Early Childhood SLPs

- Perceptions
    - How do you define cultural competency and linguistic diversity?
    - What is your level of cultural competence during intervention (i.e., the diagnostic and treatment process) specific to clients whose primary home language is not English?
- Training
    - How was your exposure to learning about culturally competent service delivery in graduate school?
    - What pre-professional and professional courses, resources, or opportunities have you had access to?
    - What initiatives does your workplace take to promote culturally competent assessment and intervention for families?
    - What are your experiences with teletherapy? How has the current pandemic affected this?
- Impacts
    - How does a family's primary language impact your relationship with them?
    - How does your relationship with families impact the intervention quality and progress for young clients whose primary language is not English?

APPENDIX C

SLP Graduate Student Demographic Questionnaire

Q1 Participant ID (provided by researcher)

____

Q2 What is your age?

____

Q3 I identify my gender as:

Male (1)
Female (2)
Non-binary/Genderqueer (3)
Other (please specify) (4) ____

Q4 What is your highest degree of education?

Bachelors (1)

Masters (2)

Research Doctorate (3)

Clinical Doctrate (4)

Q5 What semester of your program are you currently in?

1st semester (1)

2nd semester (3)

3rd semester (4)

4th semester (5)

5th semester (6)

Other (2) ____

Q6 Do you have plans to pursue further studies after your masters program?

No (1)

Yes, Research Doctorate (2)

Yes, Clinical Doctorate program (3)

Unsure (5)

Other (please specify) (4) ____

Q7 What state is your university located?

____

Q8 What is the current format of your graduate program?

In person (1)

Online (2)

Hybrid (in person/online) (3)

Q9 What racial-ethnic background do you identify as?

- [ ] White (1)
- [ ] Black or African American (2)
- [ ] Native American (3)
- [ ] Asian (4)
- [ ] Pacific Islander (5)
- [ ] Other (6) ____

Q10 Did you speak any languages other than English

No (1)

Yes, please specify (2) ____

Q11 Do you understand any languages other than English?

No (1)

Yes, please specify (2) ____

APPENDIX D

Semi-Structured Interview Questions for SLP Graduate Students

- Perceptions
    - How do you define cultural competency?
    - How do you define linguistic diversity?
    - What is your level of cultural competence specific to clients whose primary home language is not English?
    - What are considerations for cultural competency in early childhood contexts?
- Training
    - How was your exposure to learning about culturally competent service delivery so far in graduate school?
    - What courses, resources, or opportunities have you had access to?
    - What initiatives does your school take to promote culturally competent assessment and intervention?
    - What are your experiences learning about teletherapy?
- Impacts
    - How do you think a family's primary language can impact your relationship with them?
    - How do you think your relationship with families could impact the intervention quality and progress for young clients whose primary language is not English?